UNIVERSITY OF ALBERTA

EVALUATING NURSES' MORAL REASONING

By

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A thesis submitted to the Faculty of Graduate Studies
and Research in partial fulfillment
of the requirements for the degree of
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DEDICATION

To Keith

The wind beneath my wings

ABSTRACT

How can one examine the effectiveness of ethics teaching? Given that there are many difficulties in measuring moral behaviour, most researchers and educators have opted to attempt to evaluate students' moral reasoning. However, this approach has been hampered by the lack of reliable and valid measurement tools. In this exploratory-descriptive study, the central research question was, "Is it possible to design a satisfactory method, using written responses to hypothetical scenarios, to evaluate moral reasoning in student nurses?"

The study was conducted in three phases. The purpose of Phase I was to identify common ethical problems experienced by nurses in practise. Nurses working in an acute care hospital were interviewed and asked to describe ethical problems they had encountered. The identified problems were used in the construction of two hypothetical scenarios. In Phase II, the scenarios were distributed to student nurses and practising nurses, who were asked to provide a written response to each. A total of 37 written responses to each scenario was received. In Phase III, twelve professors and instructors from faculties and schools of nursing across the province were asked to sort the written responses into piles according to perceived quality; they were then interviewed about why

they sorted as they did. The objective was to develop a generic "best response" to the ethical problems in the scenarios.

Results showed remarkably little agreement among faculty members as to the quality of responses; answers rated as "best" by some faculty were rated as "worst" by others. In deciding on the morally correct action for the nurses in the scenarios, respondents and faculty were seen to weigh professional/institutional obligations against considerations of "patient as person", in an attempt to balance "beneficence" with the need to "preserve self". How each individual viewed the situation in the scenario was determined by her knowledge, attitudes and values, that is, by "nurse as person", rather than by an agreed-upon professional ethic. The lack of agreement among faculty made it impossible to develop a "best response" to the scenarios. It was concluded that in the absence of a well-developed nursing ethic, reliable and valid evaluation of nurses' thinking about ethical problems is an unachievable goal.

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CHAPTER 1: STATEMENT OF THE PROBLEM

Well, I think my hardest thing is with elderly people and what we do to bring them back to life after they pretty well have had it, or when they want to die and they keep saying they don't want to do this, they don't want to do this, and we're still giving treatments to them that involve pain and involve going against what they want to do. A lot of times [while they are] waiting for a nursing home, they contract something while they are in hospital and meanwhile we treat it and they just...lots of times they grow sicker from the treatments we give them. They don't want to go through it anymore (Tape 13).

I know I looked after this person for three 12-hour shifts in a row and I really questioned whether nursing in this capacity -- would I want it anymore? It was the one time in my whole nursing that I thought, I don't believe in what we're doing...I almost quit nursing over it. Because you see people come in and say, oh, her liver is doing great, and you look at this person who is basically rotting from every other area and you think, can't you see what's going on in here,

> are you so tunnelled that there's just the one thing you're involved with and you can't see the patient as a person anymore? That you see the liver...and I was very close to leaving nursing because I just couldn't believe in what they were doing at all (Tape 12).

These are the voices of nurses, describing their experiences of ethical problems in clinical practice. Their words paint powerful pictures of vulnerable patients whose humanity is lost among a welter of clicking and sighing machines, of lines and tubes and endless pain. In acute care institutions, where technology has made it possible to deny death almost indefinitely, it is nurses who clean, care, and comfort. But it is also nurses who inflict the pain, and who administer the life-prolonging elements.

The new technologies, and the possibilities inherent in health care today, have resulted in nurses facing ethical challenges unimagined even a decade ago. A recent study revealed that nursing undergraduate students equate ethics in nursing with "respect" and "caring" (Kelly, 1992). Yet how is a nurse in practice to decide on the "right" thing to do in a situation where respect for the patient seems to be in conflict with medical conceptions of care (Cooper, 1988; Gadow,

1985)? Research confirms that these questions are the source of considerable distress for nurses (Cooper, 1991; Parker, 1990).

How can nurses be helped to make better decisions at the bedside? Students are taught "the nursing process", but the sterile steps described in textbooks shed little light on the kinds of complex problems faced by nurses in the acute care setting (Allmark, 1992; Hiraki, 1992). Courses in nursing ethics, designed to teach the "ethical norms of the nursing profession: the values, virtues, and principles that are supposed to govern and guide nurses in everyday practice" (Yeo, 1991, p.2), are sometimes offered in undergraduate programs, and textbooks on nursing ethics abound (Davis & Aroskar, 1991; Jameton, 1984; Thompson, Melia, & Boyd, 1988; Veatch & Fry, 1987; and Yeo, 1991, to name but a few). Yet many educators believe that traditional approaches to teaching ethics fail to meet the needs of nurses in practice, and there is controversy regarding when and how ethics should be taught.

The debate, in part, turns on the belief that nursing ethics is highly context-bound, and cannot be taught in isolation from the nursing content upon which it reflects (Duckett, Waithe, Boyer, Schmitz, & Ryden, 1990). In response to this fairly convincing argument,

the trend in Alberta has been away from formal ethics courses in undergraduate programs, in favour of an incorporation of ethical content into more general courses in nursing theory and practice. In their newly revised curricula, all three university nursing programs in Alberta have, for the present, waived the option of formal ethics courses for undergraduates; instead, ethics content will be "pulled through as a curricular thread", that is, incorporated into general nursing courses throughout the length of the programs (personal communications).

The result of these decisions is that most faculty teaching at the undergraduate level will be involved in teaching nursing ethics, regardless of whether or not they have received formal ethics education. Moreover, they will be expected to evaluate students on the quality of their ethical thinking, and to make decisions about whether teaching goals have been accomplished. These are formidable demands.

What strategies are available to help faculty meet these demands? Debates in the literature question the very nature of nursing ethics (Cooper, 1991; Fry, 1989, 1991; Griener, 1991; Omery, 1989; Yarling & McElmurry, 1985; Yeo, 1989), and there is growing indication that traditional methods of examining moral reasoning are inadequate (Cooper, 1991). Thus, parameters of nursing

ethics are unclear, and there is no accepted standard for examining the quality of ethical thinking in nursing. Clearly, a better understanding of the values and beliefs underlying ethics teaching, and better ways of approaching the question of evaluation are required.

This study was a beginning exploration of some of the questions surrounding the teaching of nursing ethics. The original focus was on evaluation, that is, on how to evaluate the quality of ethical thinking in student nurses. However, as the study progressed, it took on the more general aspects of a study in professional values. Like many studies of this nature, it raised more questions than it answered, but, as is often the case, the questions themselves proved illuminating. Some old ideas about the validity of evaluation methods were challenged, some new ideas about nursing decision-making were raised, and perhaps most importantly, new directions for research were envisioned. In the following pages, the process and results of this exploration will be described.

CHAPTER 2: REVIEW OF THE LITERATURE

When contemplating a study in nursing ethics, particularly in the area of ethical reasoning, one is immediately struck by the complexity of the problem. The first difficulty is one which can be easily dispatched. Many authors make the (often erroneous) assumption that the terms they use have common meaning; to obviate this problem here, terms used most frequently are defined. Other difficulties, which are not so easily dealt with, fall into two categories: methodological considerations and theoretical considerations. The two, of course, are closely linked, but an attempt will be made to separate the issues for the sake of this discussion.

If the purpose of teaching ethics is to improve ethical decision-making in practice, then what one would like to do is examine changes in behaviour associated with that teaching. However, this type of evaluation is limited by a number of practical problems. Clearly, pre-and post-course behavioral comparisons are impossible; there is no way to control the exposure of the individual to ethical problems in practice. Moreover, moral decisions are decisions about value, in terms of "ought", and there is not likely to be a single definition of what is "right" in any given situation (Colby & Kohlberg, 1987; Marshall,

1992), which makes the evaluation of behaviour in the practice setting very difficult.

Given the problems in evaluating moral behaviour, a logical alternative would be to examine an individual's moral reasoning, that is, the way in which an individual interprets a situation and selects a morally correct course of action. Although the relationship between how an individual thinks about a moral question and what he or she does about it is far from direct (Ketefian, 1982; Kohlberg & Candee, 1984; Rest, 1982), most researchers have opted to examine moral reasoning, in the belief that if an individual's reasoning skills are enhanced, morally appropriate behaviour is more likely to result. But how can moral reasoning best be examined? These are methodological questions.

Theoretical concerns, in this discussion, relate to the nature of what is being studied. Questions such as, "What is the essence of moral reasoning in nursing? What are we **really** looking **at**?" are at issue. The issue of the nature of nursing ethics has been the focus of an intense debate in the nursing literature (see, for example, Bishop & Scudder, 1987; Brody, 1988; Cooper, 1988; Fry, 1989; Twomey, 1989; Yarling & McElmurry, 1986). A closely related and probably equally contentious issue for consideration is that of

how moral reasoning develops. Is the process of moral reasoning sequential and invariant across all individuals? If a person reaches a certain general level of moral development, will that level necessarily be reflected in decisions made in the professional context?

The questions of interest in this study, for the most part, reduce to: What does ethical thinking in nursing "look" like? How is it related to general issues of moral development? Can it be measured, and if so, how? Clearly, the relationship between theory and method is strong; the choice of method is driven by underlying theoretical assumptions. This relationship will be further examined below, in justification of the method chosen for this research.

Definition of Terms

Each day, a nurse must make many professional decisions. Many of these are quite straightforward, involving simple knowledge of procedure or scientific principles. Some, however, are much more difficult, as they involve questions of right and wrong, that is, of **morality** or **ethics**. The two terms are often used interchangeably. According to Thompson, Melia and Boyd (1988), "morals, (and also morality) ... tends to refer to the standards of behaviour actually held or followed by individuals and groups, while ethics refers to the

science or study of morals." (p. 1-2) However, "ethics can also be used to refer to the morals or morality of certain groups, such as the professions, and sometimes to the morals or morality of individuals" (Thompson, Melia, & Boyd, 1988, p. 2). In this study, "moral" and "ethical" will be used interchangeably to denote considerations of "right" behaviour.

Jameton (1984) has described three types of moral problems that can be experienced by the professional, particularly the nurse, in the institutional setting. **Moral uncertainty** arises when one is unsure what moral principles or values apply, or even what the moral problem is ...[whereas] **moral dilemmas** arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action" (p. 6.). A third problem, **moral distress**, arises when an individual has a belief about what should be done, but is prevented from doing it by institutional constraints.

Theoretical Considerations

As was mentioned above, one of the problems in studying nursing ethics is that there is no consensus on what nursing ethics is. The conversation at present is focused on two seemingly opposite approaches to moral philosophy: what has been characterized as the "care" versus "justice" dichotomy (Shogan, 1988).

Although this debate is by no means exclusive to nursing (Baier, 1987a), it stands as the basis for many of the criticisms currently levelled against bioethical theory, and as such is of particular importance to discussions of the moral reasoning of nurses. Elements in the debate have borrowed from, and had impact on all branches of ethical study, for they deal with questions of what one "ought" to do and how one comes to know the nature of that "ought". To understand the character of the controversy, then, one must first understand how it fits into the broader context of ethical theory.

The philosophical study of ethics includes metaethics, normative ethics, and applied ethics (Holmes, 1990). **Metaethics** involves analysis of ethical concepts, addressing such questions as what makes acts right. **Normative ethics** deals with principles or norms that are generally agreed to make acts right or wrong. Analysis of specific moral problems, such as abortion or euthanasia, is the realm of **applied ethics**. According to Holmes (1990), "all three may be distinguished from ... substantive morality, the ongoing process of making moral judgments that all of us engage in during the course of living" (p. 145).

Normative Ethics

When people speak of ethical theory, they are

usually talking about normative ethics. A large number of ethical theories have been defined, dating back to Plato and earlier (Solomon, 1984), but perhaps the most well-known are the deontological theory of Immanuel Kant and the utilitarian theory of John Stuart Mill. Kant's (1785/1959) categorical imperative suggests that "an action has moral worth only if performed by an agent who possesses ... a good will; and a person has a good will only if moral duty based on a valid rule is the sole motive of action" (Beauchamp & Childress, 1989, p. 38). The main precept of Mill's (1861/1979) theory of utilitarianism is "the greatest good for the greatest number". Although these theories are widely different in their assumptions and dictums, what they have in common is a reliance on absolute principles, the appropriate application of which can be derived through reason.

A more recent normative theory is John Rawls Theory of Justice (1971). To Rawls, moral acts are defined in terms of justice, the main principles of which are liberty and fair distribution of social and economic goods. In this social contract theory, reason again is the hallmark; the achievement of just ends depends on logic and appropriate application of rules. Since it was introduced, Rawls' theory has had an important impact in philosophical circles, and has been

the basis of much work in ethical reasoning, as shall be demonstrated.

Applied Ethics

Within the practice setting, if the individual is to take action, he or she must decide among ethical values pertaining to any given problem. If two or more values conflict, a decision must be made as to which is paramount. One would expect this decision to be guided by ethical theory, but Holmes (1990) suggests that this is not realistic. He maintains that "one cannot 'apply' theories like Kantianism or [utilitarianism] to get solutions to practical moral problems unless one knows which theory is correct, and that is a metaethical question over which there is no consensus" (p. 143).

To assist practitioners in resolving ethical dilemmas, professions have developed codes of ethics. For the most part, however, these codes fail to provide answers to genuine moral dilemmas; they merely offer general advice that is open to interpretation. The difficulties inherent in trying to "apply" normative theories to practical ethical problems in health care, and in trying to use codes of ethics as arbiters in ethical dilemmas resulted in the development of a new discipline called bioethics (Griener, 1991), which, according to Holmes (1990), falls in the realm of

applied ethics. Perhaps the best known explication of bioethical theory is by Beauchamp and Childress (1988).

The approach to professional morality advocated by Beauchamp and Childress (1988) borrows from deontological, utilitarian, and social contract theory, and is thus oriented to rules and principles and their correlative rights and obligations. Beauchamp and Childress argue that resolution of moral problems in the professional context can be accomplished through application of "four basic principles ... and several derivative rules ..., all of which are prima facie obligatory" (p. 62). The four principles are autonomy, nonmaleficence (do no harm), beneficence (do good) and justice.

The utility of this approach to bioethical problems has recently been criticized, however. Clouser and Gert (1990) take strong exception to the idea that principles as such are guides to action; rather, principles are "merely names for a collection of sometimes superficially related matters for consideration when dealing with a moral problem" (p. 219). Principles, they maintain, are not derived from any unified moral theory, and are therefore not systematically related to each other. As a result, it is impossible to determine which principle is paramount in any given situation, and moral problems in which

principles conflict are all unresolvable. As Brody (1990) has pointed out, much work needs to be done in relating principles to theories before principles have much practical value.

Challenges to Traditional Approaches: The Debate

According to Gustafson (1990), bioethics involves "the framing of problems and solutions by a relatively small set of concepts: rights, duties, obligations, competence, and justice" (p. 127). This, however, is predicated on a number of implicit (metaethical) assumptions that have been poorly articulated (Gustafson, 1990). The primary assumption is that right can be defined through rules and principles. Feminist philosophers take exception; they contend that bioethics, (as well as most normative ethical theories), are "built on assumptions and concepts that are by no means gender-neutral" (Held, 1990, p. 321), and that an ethic based on rights and principles fails to take into account the experience of women, which is rooted in connectedness and caring (Baier, 1987b; Meyers, 1987; Meyers & Kittay, 1987; Noddings, 1984). Held (1984) asserts that moral theory generally uses the economic exchange between buyer and seller as a model for human relationships, neglecting the kind of relatedness that characterizes women's way of thinking. Although she accepts principled thinking as important,

she cautions that to ignore the alternative way of viewing the world is to leave moral theory incomplete. Noddings (1984) agrees. She states:

> The long-standing emphasis on the study of moral judgments has led to a serious imbalance in moral discussion. In particular, it is well known that many women--perhaps most women--do not approach moral problems as problems of principle, reasoning, and judgment....If a substantial segment of humankind approaches moral problems through a consideration of the concrete elements of situations and a regard for themselves as caring, then perhaps an attempt should be made to enlighten the study of morality in this alternative mode. (p. 28)

If one extends the above argument to professional ethics, one might well conclude that bioethical theory, which is based on a principled reasoning approach, is inadequate as a guide for nurses attempting to resolve ethical problems. The caring that is central to nursing may require a different type of reasoning than is represented in bioethics. And indeed, a number of authors have criticized bioethics for precisely that reason. The centrality of caring to nursing is the theme of a number of authors who have advocated a new approach to nursing ethics (Cooper, 1988, 1991; Gadow,

1985; Packard & Ferrara, 1988; Parker, 1990; Raatikainen, 1989; Yeo, 1989). Fry (1989, 1991) maintains that current theories of bioethics are inappropriate for nursing, and points to the need for a separate nursing ethic based on the caring relationship between nurse and patient, rather than on traditional models of patient good, rights-based autonomy, and social contract. Twomey (1989) echoes this sentiment, asserting that nursing ethics is distinct from bioethics, and that the essential distinction can be identified through a metaethical analysis of the definition of good. This "good", he suggests, is rooted in the caring relationship between patient and nurse.

In a similar vein, Brody (1988) calls for a return to "virtue ethics", which involves considerations of character, and the degree to which an individual possesses certain "virtues" expected to lead to "right" behaviour. In virtue ethics, emphasis is placed on the agent, not the action. According to Brody (1988), caring is the central virtue for nursing, and can help one choose between opposing principles. Therefore, the virtuous nurse must be a caring nurse, and in evaluating moral conduct in nursing, one must consider caring as a moral ideal. Fry (1988) supports this contention, and suggests that virtue ethics can

"provide new opportunities for research on the moral foundations of nursing practice" (p. 100).

Although the need for a nursing ethic separate from bioethics can be disputed (Boyer & Nelson, 1990; Griener, 1991), it seems evident that bioethical theory as currently defined has important deficiencies for nursing. Knowledge of bioethical theory per se may have little relevance to actual decision-making at the bedside. One can conclude from this that bioethical theory neither provides adequate direction for nurses in clinical decision-making, nor offers an appropriate framework for evaluation of the quality of moral decisions in practice.

Moral Development

In a pluralistic society, it may be impossible to come to agreement about what constitutes "right". However, there seems to be general agreement that individuals can learn over time to make "better" (in essence, more normative) decisions. How does an individual come to know what is morally appropriate or acceptable behaviour? On this topic, too, there is controversy. Again the dispute rests in perceived differences between "masculine" and "feminine" ways of knowing.

Among those attempting to answer questions about the acquisition of moral understandings, cognitive-

developmental theorists, including Lawrence Kohlberg (1981, 1984; Colby & Kohlberg, 1987) and James Rest (1987), have dominated the field. Kohlberg's and Rest's work is rule- or justice-oriented, and is based on Piaget's (1965) stage theory, supported by Rawls' (1971) Theory of Justice. Their research suggests that an individual's moral reasoning develops in an invariant sequence of three levels, divided into six stages, as shown in Figure 2.1. Thus, moral development is seen as progressing from a highly egocentric position to one in which application of abstract rules or principles governs decision making.

This principled reasoning approach for many years served as a kind of "gold standard" in any discussions about moral reasoning and its measurement. However, it has recently been strongly criticized by a number of philosophers and psychologists, particularly those with a feminist perspective (Gilligan, 1982, 1988a, 1988b, 1988c; Johnston, 1986; Lyons, 1988; Noddings 1984, 1989). Much of the censure has been levelled at Kohlberg, whose stage theory formed the basis for Rest's work. The chief concern is that Kohlberg used only male subjects in the longitudinal study on which he based his theory, with the result that his research is systematically biased. He nonetheless claims that his theory has universal application.

Figure 2.1 Kohlberg's Moral Judgment Stages

I. **Preconventional Level (Premoral Level).** A person follows society's rules of right and wrong but in terms of the consequences (punishment, reward, exchange of favors) and in view of the power of authority.

> **Stage 1.** Punishment and obedience orientation. Whether an action is good or bad depends on whether it results in punishment or reward.
>
> **Stage 2.** Naive instrumental orientation. Proper action instrumentally satisfies the individual's needs and occasionally the needs of others.

II. **Conventional Level.** A person conforms to the expectations of family, group, or nation, actively supporting and justifying existing social order.

> **Stage 3.** Good-boy, nice-girl orientation. A person acts in ways that please or help others and are approved by them.
>
> **Stage 4.** Law-and-order orientation. Right involves doing duty, showing respect for authority, and maintaining the existing social order.

III. **Postconventional, Principles, or Autonomous Level.** A person tries to identify universal moral values that are valid, regardless of what authority or group subscribes to those values.

> **Stage 5.** Social contract orientation. Moral behavior is defined in terms of general individual rights and according to standards that have been critically examined and to which the whole society has given its consent.
>
> **Stage 6.** Universal ethical principle orientation. Moral judgments are based on universal principles of justice, on the reciprocity and equality of human rights, and on respect for the dignity of humans as individual persons.

Adapted from Thomas, 1985, p. 356.

Gilligan suggests otherwise; her research provides some evidence that female moral development is also stage sequenced, but follows a path very different from that described by Kohlberg. Gilligan points out that, whereas development of the young male is characterized by a growing detachment from the mother, and increasing objectivity, the growth of a young female is marked by no such detachment; rather, the female child develops a growing sense of connectedness with and care for others. The result is the unfolding of a feminine ethic of "care", which Gilligan contrasts with the masculine ethic of "justice" described by Kohlberg (Gilligan, 1982, 1987).

In later work, Gilligan (1988c) and others (Allen, Allman, & Powers, 1991) have indicated that this alternate way of knowing is not exclusively the province of women. Rather, it is more evident in women, but is certainly present in men; it does not appear, however, to be the preferred way of dealing with moral problems for the majority of males (Johnston, 1988; Lyons, 1988).

The suggestion that an individual views the world predominantly from either a care or a justice perspective has been hotly contested (Nunner-Winkler, 1984; Rest, Thoma, Moon, & Getz, 1986; Kohlberg, 1987). There is, however, a middle-of-the-road position that

acknowledges both care and justice as aspects of moral development, suggesting that the two must be balanced in any workable moral theory (Sher, 1987). Shogan (1988) suggests that care can be understood as moral motivation, and that this does not preclude the application of justice principles in the interest of caring. Again, in considering caring as a personal characteristic, these arguments seem akin to virtue ethics. One theory that seems to pull these disparate viewpoints of justice, care and virtue together is Dabrowski's (1964) theory of positive disintegration, which incorporates the concept of virtue and values in a hierarchy of developmental stages. In Dabrowski's theory, higher levels are characterized by superior subject-object relationships and authentic relatedness (Hague, 1986, 1990). Thus, although the care-justice dichotomy is in dispute, there is considerable support for the existence of a way of knowing that is separate from, and complementary to, a justice perspective of morality.

Methodological Issues

The argument that there are two fundamental ways of thinking about ethical questions raises a number of methodological questions. The first concern is, of course, with the most valid approach to evaluation. If one wishes to examine the quality of ethical reasoning

in nurses, what should one be examining, and what instruments/methods should be used?

Measuring Moral Development

Most of the research in moral development to date has been based on principle-oriented reasoning. Both Kohlberg and Rest have developed instruments to determine the stage at which an individual reasons about moral questions. Kohlberg's Moral Judgment Interview (MJI) is highly sophisticated and complex. It consists of three parallel forms, each of which comprises three hypothetical moral dilemmas. The respondent is presented with the dilemmas and asked what he/she thinks should be done. A number of probe questions are used to elicit justifications, elaborations and clarifications (Colby & Kohlberg, 1987). Interviews are tape-recorded, analyzed and scored according to Kohlberg's stage theory. Considerable effort has gone into establishing reliability and validity of the MJI (Colby & Kohlberg, 1984; 1987).

Rest's Defining Issues Test is a paper-and-pencil test that is much quicker and easier to administer and score than the MJI. It uses the same hypothetical dilemmas developed by Kohlberg, but the respondent is asked to indicate from among a list of options what he/she thinks should be done. Each dilemma is

accompanied by a list of 12 statements that might have contributed to the respondent's decision about what should be done; the respondent is asked to rate on a 5-point scale how much each item influenced the decision. The final task involves rating the statements from first to fourth in order of importance. The DIT has been well validated and extensively utilized as a measure of principled reasoning (Rest, 1987).

Ethics Research in Nursing

The majority of nurse researchers studying in the area of ethics and moral reasoning have based their work on the principled reasoning (justice-oriented) approach (Ketefian & Ormond, 1988; Ketefian, 1989). For example, Hembree (1988), Felton and Parsons (1987), Stoll (1989) and Mayberry (1986), used the DIT to examine the relationship between educational preparation and moral reasoning in nurses or student nurses. Results of all four studies showed a statistically significant relationship between education and moral reasoning, but the correlations were so weak as to be of little practical importance.

Ketefian (1981) took a slightly different approach. She developed a new scale, the "Judgments about Nursing Decisions" (JAND), designed to measure nurse's moral reasoning and, ostensibly, their behaviour, with respect to ethical problems in clinical

practice. Then, to examine the "implicit assumption ... that persons at higher moral reasoning stages are more likely to act 'morally' than those who are at lower stages" (p. 172), she administered the DIT and correlated DIT scores with JAND scores. Although the correlations were statistically significant, they were of low magnitude. Despite apparent problems with the reliability of the JAND (Ketefian, 1987), other researchers have also used it, again with inconclusive results (Gaul, 1986, 1987). Examining outcomes of research using this instrument, Ketefian noted that

> due to the low magnitudes of the relationships, no definitive conclusions can be drawn. Thus, knowledge of linkages in a proposed model [of ethical decision-making] must remain tentative until further testing and replication occur (Ketefian, 1987, p. 17)

Crisham's (1981) Nursing Dilemmas Test (NDT) is another instrument designed specifically to examine moral reasoning in nurses. Based on interviews with 130 nurses, the NDT consists of six dilemmas that were repeatedly identified by nurses as occurring in their practice. Answers to the dilemmas were established by interviews with nurses, and were coded by two moral judgment "experts" according to Rest's stage definitions. The final format of the instrument is

similar to that of the DIT. The NDT has been used by faculty at the University of Minnesota, where an extensive program to teach nursing ethics is being developed (Duckett, Waithe, Boyer, Schmitz, & Ryden, 1990), but to date has proven disappointingly unreliable as a measure of moral reasoning. Moreover, in the opinion of a committee of nurse experts attempting to establish a method of evaluating ethics teaching in a nursing programme, the dilemmas are not applicable to the Canadian nursing scene. Another criticism launched by the same committee is that the dilemmas in the NDT do not appear to be reflective of true **nursing** problems; they describe situations over which nurses have no control (T. Gusheliak, personal communication, March 10, 1991).

From the above discussion, it is evident that the principles-oriented instruments have yielded unsatisfactory results in the study of moral thinking in nurses. Does the problem reside merely in the instruments themselves, or in the philosophical assumptions on which the research was based? There is some evidence to suggest that the answer is, "both".

Important criticisms of the DIT-type instruments are related to their conceptual underpinnings. Several authors have questioned whether justice-based or principles-oriented instruments are suitable for

measuring moral reasoning in nursing. If, as has been suggested, the foundational ethic for nursing is one of care (Fry, 1989; Parker, 1990; Yeo, 1989) the methods defined by Kohlberg and Rest may be inappropriate (Huggins & Scalzi, 1988; Nokes, 1989; Reed, 1989). Moreover, Goodpaster (1982) argues that stage theory presumes a monistic view, that is, that ethical decision-making is guided by a single basic principle, but that adults are unlikely to use a simple "recipe" for solving ethical problems. Instead, they use more complex decision-making frameworks, which "points to more variance than can be measured or evaluated by the usual methods of 'stage and sequence'" (Goodpaster, 1982, p. 39).

Munhall (1982), in an extensive critique of her own study in which she used the DIT to measure nurses' moral reasoning, indicated that the DIT is too limiting because it is oriented exclusively toward a justice perspective. In her study nurses' average DIT scores were at the Conventional level, which Munhall suggested could be evidence that they were using a mode of reasoning based on connectedness and caring, rather than principles.

From a methodological perspective, Whitbeck (1992), in a thoughtful analysis of current methods of measuring moral reasoning, takes strong exception to

the forced-choice type of approach. In her view,

> Representation of moral problems as multiple-choice or 'decision problems' abstracts away from temporal unfolding and from expression and development of moral character. It also ignores the synthetic character of devising solutions (p. 123).

She argues that the typical way in which moral reasoning is taught (and measured) results in "the abstract representation of moral problems as 'math problems with human beings'" (p. 125), which ignores the fact that

> The person who is trying to decide what to do typically faces such questions as: whether (and how) to gather more evidence, how to raise the issue (or gather more evidence) without being unfair to others, how best to elicit support for her moral concern, etc. She must also decide what to do first and how to go about doing it in the particular environment in which she finds herself... (p. 132).

Implicit in Whitbeck's (1992) argument is a criticism of the rule-oriented approach in general. She suggests that moral problem-solving involves far more than the application of an ordered set of moral principles, and that the complexity of such problem-

solving can only be captured through narrative.

Echoing these sentiments, Uden and colleagues (Uden, Norberg, Lindseth, & Marhaug, 1992) note that "human experiences are always understood within a whole which gives them meaning" (p. 1028). Therefore, they maintain that the best way to get to an individual's moral understandings is through narrative. They maintain that " the story can be supposed to give a more comprehensive view of ethical reasoning than answers" (p. 1029).

Researchers who have used qualitative methods have found support for the contention that a singular focus on principled reasoning may be inappropriate for examining nurses' moral reasoning. McNamara (1989) interviewed 24 nurses and categorized their responses as coming from a "mostly caring" or "mostly justice" perspective. The majority of subjects (n=17) expressed a caring-focused orientation. Similarly, Akerlund and Norberg (1985) interviewed 39 nurses about how they felt about "force-feeding" demented patients and found that nurses used a pluralistic approach to decision-making; that is, they used a variety of ethical beliefs to help them decide on the right course of action. The authors concluded that the principled reasoning approach as outlined in stage theory was inadequate to inform nursing practice. Another study involving

interviews with ten practising nurses (Omery, 1985) revealed that the subjects' moral reasoning was characterized by consideration of both principles and context.

In a somewhat different approach, Beaugard (1990) first interviewed 51 nurses about moral problems they experienced in practice, and from these interviews developed a standardized dilemma that reflected the most commonly appearing ethical concerns. She then interviewed 21 nurses, asking them how they would resolve the dilemma. Analysis of the responses revealed three self-other orientations which formed the basis of the subjects' moral reasoning. On the basis of her results, she recommended further research into the area of moral development, indicating that current theories are inadequate to explain nurses' moral reasoning.

Thus, the combined criticisms of feminist philosophers, developmental psychologists, and nurse researchers suggest that the methods used to date in studying moral reasoning in nurses have been deficient. There appears to be an element of moral thinking that has been missed in traditional approaches. This element, which has been described as representing the "feminine" experience of caring and connectedness, seems to have particular relevance for nursing,

although research has suggested that it is a consideration in other professions as well (Jack & Jack, 1988, 1989; Gilligan & Pollak, 1988). Evidence is accumulating that a nursing ethic defined in terms of response and care might look very different from an ethic defined in terms of principled reasoning. If this is indeed the case, it must be considered in examination of nurses' moral development and in evaluating the effectiveness of ethics teaching.

Summary: Clarifying Concepts

In summary, the discussion to this point has touched on philosophical ethics, applied ethics, moral development theory and measurement, and research in nursing ethics and moral reasoning. An attempt will now be made to bring these divergent topics together.

First, the argument has been made that traditional ethical theories (since Kant, such as those of Mill and Rawls), share a central presupposition: that answers to questions of moral behaviour, that is, of what "ought" to be done, can be derived through reason. The ideas of these philosophers have lead to the belief that "philosophical ethics ought to provide a decision procedure -- a way of settling matters, especially in the case of conflicting values or interest -- and to do so by formulating and ordering 'principles' in the sense of universal injunctions" (Whitbeck, 1992, p.

122).

Linking traditional normative ethics with developmental theory, psychologists have tried to explain how an individual learns to reason about moral problems, and comes to understand the appropriate application of moral principles. Lawrence Kohlberg posited an invariant sequence of moral development, in which a person moves through six stages, the first of which is characterized by egocentricity in decision-making, and the last of which is characterized by application of universal ethical principles. Kohlberg's theory formed the basis for the development of two instruments, the MJI and the DIT, designed to measure the stage at which an individual is reasoning.

During approximately the same time period that Kohlberg was promulgating his stage theory, a new theory in applied ethics was growing and flourishing. When normative ethical theories failed to provide the direction health care practitioners required for clinical decision-making, bioethics was spawned. This applied theory borrowed from earlier theories in the sense that it, too, rested on the supposition that rules or principles, derived and ordered through reason, could provide the answers to moral questions.

Nursing, searching for an ethical theory to guide decision-making, quickly adopted the tenets of

bioethics. The assumption seemed to be that the "ethically skilled" practitioner would be better able to "apply" bioethical principles in practice. From this reasoning, it seemed logical to measure the skill of nurses at applying rules, in part to determine if education and experience had any impact on this ability in the clinical context. It was assumed that a general facility with rule-application would transfer to practice settings, so most of the initial research was carried out using the DIT to measure nurses' moral reasoning.

Unsatisfied with the results of these studies, researchers began to suspect that it was important to test nurses' ability to think about specific clinical problems, and several instruments patterned after the DIT, but with nursing-specific content, were developed. To the surprise of researchers, studies using these instruments, too, failed to provide the required information about nursing decision-making and the effectiveness of ethics teaching on improving decision-making skill.

While Kohlberg's stage theory was gaining wide acceptance, a groundswell was rising in feminist psychology and ethics. The work of Carol Gilligan and Nel Noddings raised important doubts about traditional beliefs in philosophical ethics and moral development.

Their point was that a principles-oriented or justice-based approach to ethics was incomplete or inadequate, for it failed to consider that moral decisions could be based on relational aspects of caring, connectedness, and nurturance. Gilligan suggested that moral reasoning, and particularly women's reasoning, could develop along very different, but equally "worthy", lines than those posited by Kohlberg. The ability to reason in the abstract, applying objective rules, was no longer viewed as the zenith by these critics.

One effect of this philosophical debate is that suddenly the appropriateness of bioethical theory for nursing has been called into question. Notions that context is important in decision making, and that the relationship of nurse with patient could be the source of valid data to inform decision-making, have caused nurse researchers and ethicists to reconsider their principles-oriented approach. One outcome is that the research methods and measurement instruments formerly accepted as suitable for examining nurses' moral reasoning have been rejected as inappropriate by a number of researchers.

In essence, then, the discussion comes to this: in view of the critique of bioethics, there is currently no agreed upon framework to guide nurses in clinical decision-making at the bedside, and the research

methods and instruments used by the majority of researchers to study nurse's moral reasoning are in disfavour. Yet nurses are facing increasingly difficult ethical decisions in their practice, and there is a belief that students must be equipped to face these challenges. Ethics continues to be a part of nursing undergraduate curricula, but how can we know if our teaching has been effective?

Assessing the Effectiveness of Ethics Teaching

The assumption underlying courses in professional ethics is that "moral theory can be learned, reasoning and sensitivity skills can be enhanced, and criteria for distinguishing morally appropriate and effective ways of implementing moral choices can be mastered" (Duckett et al., 1990, p. B-1). The ultimate goal of ethics teaching is to improve ethical decision-making, and as was pointed out above, the "acid test" of its effectiveness would be to observe changes in moral behavior in practice. However, because practical problems preclude this approach, alternative methods are required. First, the student's level of knowledge about ethical theory can be examined. This is a reasonably uncomplicated task that involves routine testing practices familiar to virtually all instructors, but, as has been seen, probably provides little insight into how an individual would be likely

to perform in practice. Sensitivity to ethical problems has been measured in medical students (Hebert, Meslin, Dunn, Byrne, & Reid, 1990), and would seem to be a fairly straightforward procedure, involving a simple count of the number of ethical issues students identify from a vignette or hypothetical scenario. Measures of sensitivity, however, do not address what the student thinks should be done about the problems that are recognized.

It appears, then, that the most profitable strategy would be to examine how a student masters "criteria for distinguishing morally appropriate and effective ways of implementing moral choices", that is, the students' moral reasoning skills. As has been indicated, however, measurement of reasoning is a much more difficult task. Of course, as has been pointed out, the relationship between what an individual thinks should be done, and what that individual will actually do, is poorly understood. A number of authors have suggested that even if nurses reason appropriately, in practice they may not act "ethically", either because, for any number of reasons, they do not have the "will" to act (Rest, Bebeau, & Volker, 1986), or because they are prevented from acting on their beliefs by the institutional and power structures in which they work (Davis, 1989; Gramelspacher, Howell, & Young, 1986;

Schattschneider, 1990; Swider, McElmurry, & Yarling, 1985; Yarling & McElmurry, 1983, 1986). However, the assumption underlying the present research is that if nurses are enabled to reason more effectively about ethical issues, they will act more appropriately. Therefore, the focus here is on finding a method for assessing nurses' moral reasoning skills.

The objections to using multiple-choice instruments, and the movement toward the use of more qualitative, narrative approaches, suggest that, if a paper-and-pencil test is to be developed, it must allow for the consideration of context, and must permit a kind of "unfolding", to use Whitbeck's (1992) word, of the problem solution. This clearly points toward an open-ended, long-answer format. Of course, that raises new problems, for if such an answer should be obtained, how is it to be "scored"?

The SOLO (Structure of Observed Learning Objectives) Taxonomy described by Biggs and Collis (1982), provides one alternative. These authors maintain that learning outcomes can be defined in terms of the structural complexity of written responses to questions. Levels of response are "ordered in terms of characteristics that include progression from concrete to abstract; an increasing number of organizing dimensions; increasing consistency; and use of

organizing or relating principles, with hypothetical or self-generated principles being used at the most complex end" (p. 14). Based on Piaget's cognitive stages, the SOLO taxonomy consists of five levels of response, as shown in Figure 2.2. In evaluating responses, Biggs and Collis are not so concerned with the actual content, as with how it is elaborated or structured. If, as Biggs and Collis suggest, structure of written responses is indicative of the sophistication of thinking about particular problems, then structure in response to questions about moral dilemmas may be important.

However, the solution may be more complex than that. In clinical nursing situations, there may be many mitigating aspects of a problem that are not immediately obvious. Consequently it is desirable that the nurse be able to integrate various pieces of information before formulating a response in a situation requiring ethical decisions. The ability to formulate a well-structured conclusion is a necessary but not sufficient condition for an acceptable response. There must also be a consideration of content. Professional culture implies intrinsic norms and values which must be considered in evaluation of an individual's thinking about professional problems. The decision reached by the nurse must be congruent with

Figure 2.2 SOLO Taxonomy of Responses

Prestructural: Confuses cue and response. Characterized by denial, tautology, and transduction. Bound to specifics. No felt need for consistency. Closes without even seeing the problem.

Unistructural: Can "generalize" only in terms of one aspect. No felt need for consistency, thus closes too quickly: jumps to conclusions on one aspect, and so can be very inconsistent.

Multistructural: Can "generalize" only in terms of a few limited and independent aspects. Although has a feeling for consistency can be inconsistent because closes too soon on basis of isolated fixations on data, and so can come to different conclusions with same data.

Relational: Induction. Can generalize within given or experienced context using related aspects. No inconsistency within the given system, but since closure is unique so inconsistencies may occur when individual goes outside the system.

Extended abstract: Deduction and induction. Can generalize to situations not experienced. Inconsistencies resolved. No felt need to give closed decisions--conclusions held open, or qualified to allow logically possible alternatives.

Adapted from Biggs & Collis (1982), pp. 24-25.

these values. As Nisan (1984) has pointed out,

> Examination of subjects' responses to moral dilemmas suggest that the norms (standards of behavior, expectations, laws, etc.) and other components of moral content (like values, definitions, and beliefs) are not generated by the structure [of moral reasoning] but are culture dependent (p. 208).

Nisan (1984) further suggests that "the content has a crucial role in determining moral decisions but may also affect the structure, that is, the level of reasoning" (p. 208). If structure and content are intertwined, both must be evaluated in assessing moral reasoning.

Biggs and Collis (1982) have described a method for examining structure, but how can congruence with professional values be evaluated? Oser (1990) talks about an "ethos", a way of thinking about moral questions that characterizes a profession. He suggests that the ethos can be "discovered" through empirical research. In one study, Oser and colleagues (1990) worked with school teachers, using what they called a "semiclinical" interview format, in an attempt to develop a way of scoring responses to teachers' ethical dilemmas. The interviewers tried to determine what the teachers viewed as adequate decisions about particular

problems. In this way, they uncovered aspects of the teachers' ethos, that is, of the value system underlying their responses. Similarly, Erickson (1990) interviewed family therapists to determine what they perceived to be ethical issues in practice, then surveyed a large number of therapists to determine the degree of consensus that existed regarding the way identified issues should be handled in practice.

In nursing research, little attention has been paid to the professional ethos or value system in analyzing nurses' responses to moral problems (Jameton & Fowler, 1989; Sheehan, 1985). If the foundational ethic or ethos of nursing is caring, then consideration should be given to caring dimensions in ethical reasoning. How those caring responses could be manifest has not been well articulated.

It is evident that if nurses' moral reasoning is to be assessed, what is needed is a method of evaluating both structure and content of their responses to moral problems. It seems reasonable to conclude that if desired content is to be congruent with nursing professional values, the definition of that content should come from those who are charged with inculcating students with professional values. By combining considerations of structure, as outlined by Biggs and Collis (1982) and considerations of content,

as defined by teachers of ethics in professional programs, one may be able to evaluate the level of sophistication of the student's response, and the degree to which it is congruent with professional values. This should obviate feminist concerns about restricting evaluation to considerations of principled reasoning, but should at the same time permit a measure of growth and development in sophistication of moral decision-making. Such was the goal of the present study.

The study was exploratory-descriptive in nature. One central question formed the basis for the design:

> Is it possible to design a satisfactory method, using written responses to hypothetical scenarios, to evaluate moral reasoning in student nurses?

In this study, the possibilities of using one method were explored. In the process of this exploration, several secondary questions were addressed:

1. What are the most commonly occurring ethical problems that nurses experience in practice in a selected acute care institution?
2. How do nurses and nursing students respond to these problems?
3. How do faculty members from various institutions rate these responses?
4. What criteria do faculty members use in rating

responses? What values underlie the rating of responses?

5. Can a "best" response to the problems be generated based on the faculty members' comments?

Study methods and results will be described in the next two chapters.

CHAPTER 3: METHOD

This study was conducted in three phases. The purpose of Phase I was to identify common ethical problems experienced by nurses in practice. The identified problems were used in the construction of two hypothetical scenarios. In Phase II, the scenarios were distributed to student nurses and practising nurses, who were asked to provide a written response to each. In Phase III, professors and instructors from faculties and schools of nursing across the province were asked to sort the written responses into piles according to perceived quality; they were then interviewed about why they sorted as they did. Data collection took place over a period of ten months; from September to November, 1991 for Phase I; January to April, 1992, for Phase II; and May through June, 1992, for Phase III. Details of each phase are outlined below.

Phase I

Obtaining the Sample

The first phase of the study was conducted in a large acute care hospital in Edmonton. Ethical approval to conduct the study was sought and obtained from the Institution Review Board. I then met with the Nursing Administration group at one of their regularly scheduled meetings and explained the purpose and

objectives of the overall study, with specific emphasis on Phase I. I indicated that I planned to interview nurses working in the adult medical-surgical and intensive care units, and would require the assistance of the Unit Managers in obtaining names of suitable candidates for interview.

During the next few days, Unit Managers in Medicine, Surgery, and Intensive Care were contacted, either in person or by telephone. All agreed to assist in the project. It was explained that a purposive sampling technique (Field & Morse, 1989), was being used, so the nurses nominated should be those who, in the opinion of the Manager, would be thoughtful and articulate on the topic of nursing ethics and ethical problems in practice. Each Manager was requested to think of suitable candidates, and to ask permission for their names and home telephone numbers to be released to me. Through this process the names of 78 nurses were obtained, all but two of whom were female.

From the list of names, approximately equal numbers of nurses were randomly selected from each of the three areas (Medicine, Surgery, and Intensive Care). A total of 42 female nurses were contacted by telephone. I explained the study in detail, and assured each nurse that participation was voluntary, and that her involvement would be kept strictly

confidential. Surprisingly, given the amount of their time that would be required, all nurses contacted agreed to be interviewed.

Conducting the Interviews

The objective in this phase of the study was to learn what nurses would define as ethical problems, and to determine what ethical problems were experienced most frequently by nurses in this setting. Consequently a broad spectrum of nurses working on a variety of units was sought. There was concern that if interviews were restricted to selected units only, the picture of nurses' ethical concerns might be too narrow. Therefore, although theoretical saturation seemed to be achieved after approximately 10 interviews, a total of 42 interviews was scheduled. Six nurses cancelled and attempted to rebook, but a mutually agreeable time could not be established. As a result, the total number of interviews conducted was 36.

Interviews took place in a site of the participant's choosing. Nurse Managers had given their permission to conduct the interviews on hospital time, and 13 nurses opted to be interviewed while they were on duty. Two interviews took place in the hospital after the participant was off duty; 11 interviews were conducted on the university campus; and 10 nurses opted

to be interviewed in their homes. In all cases, the interview took place in a quiet, private setting.

At the time of the interview, I again explained the study briefly, and provided the participant with a written explanation of the study (Appendix A) and a detailed consent form (Appendix B). After the participant had read and signed the consent, the audio tape recorder was turned on, and the interview commenced.

The lead question for the interview was phrased very carefully. Each nurse was asked, "Please describe for me an ethical problem that you have had in your practice -- something that was a problem for you." The word "problem" was chosen instead of the word "dilemma", as it was felt that "dilemma" would connote to the participant some of the typical cases described in ethics textbooks. What was desired was a definition of ethical concerns rooted in everyday practice, and "problem" allowed more scope in the response. Dilemma, by definition, involves a choice between two or more values of equal strength. Problem, on the other hand, includes not just choices between competing values, but other aspects of moral life, including what Jameton (1984) refers to as "moral distress".

Once the lead question had been asked, the interview was completely open-ended. Probes were used

as appropriate, but there was no fixed interview schedule. Nurses occasionally asked what was meant by "ethical problem", and were reminded that the objective was to find out what they defined as an ethical problem, not what anyone else thought. Given that response, all nurses were then able to proceed without apparent difficulty.

Analysis of the Interviews

Once the interviews were completed, they were transcribed verbatim. I read each interview carefully several times, highlighting the major ethical themes. Since the purpose of this phase of the study was to discover common ethical problems, but not necessarily to expand ethical theory per se, a more detailed conceptual analysis was not carried out at this time. However, all subjects gave their verbal assent to the use of the data for further analysis after the completion of this study.

Development of the Scenarios

The most frequently appearing themes were extracted from the interviews and used to develop two hypothetical scenarios in which a nurse was faced with a problem requiring action. Each scenario was a composite of a number of different ethical concerns that had been raised in the interviews. Details of the identification of themes and the development of the

scenarios are outlined in the "Results" section of this report.

Once the scenarios were developed, they were distributed to five nurses (two Clinical Nurse Specialists, two Unit Managers, and one clinical educator) working in the hospital setting and considered by their Supervisors to be expert clinicians. None of the expert nurses had been involved in the initial interviews. Each was asked to review the two scenarios to determine if they appeared to represent "real" situations.

Phase II

Obtaining the Sample

For this portion of the study the assistance of both practising nurses and student nurses was sought. From the list of practising nurses obtained in Phase I, those who had not been involved in interviews were contacted by telephone. The study was explained in detail and the nurse asked if she or he wished to participate. Each nurse was assured that his or her participation would be kept completely confidential. Twenty-five nurses were contacted; all agreed to take part in the study.

To access student nurses, application was made to the School of Nursing at one city hospital. Once the study had received ethics approval, presentations were

scheduled for classes of students at each level of the program. In all, four presentations were made. During each presentation, the study was explained briefly and a sheet of paper circulated, on which the students could write their names and telephone numbers if they were interested in hearing more about the study. They were assured that they were under no obligation to participate, even if they added their names to the list. In total, 79 names were received, approximately evenly distributed across the four levels of the program. Twenty-five of the students were randomly selected from the list and contacted by telephone. All students agreed to participate.

Distribution of Scenarios

The following were mailed to each of the 50 participants at his or her home address: an explanation of the study (Appendix A); a consent form (Appendix B); an instruction sheet (Appendix C); the two scenarios; two blank answer sheets; a sheet on which there were several demographic questions (Appendix D); and a stamped envelope addressed to my home. Each participant was requested to write a response to the questions at the end of each scenario, and to return these responses, together with the completed demographic sheet and the signed consent, in the return envelope. A deadline date was set for three weeks from

the date of the mail-out.

The consent form had been printed on coloured paper to make it easily identifiable. When responses were received, the consent form was immediately removed and filed. The written responses were then filed separately; in that way, it was impossible to identify a respondent with his or her response. To further protect confidentiality of the participants, all the responses were typed, thus ensuring that individuals could not be identified through their handwriting. This was particulary important for students, who might have been concerned about being identified by faculty members reviewing the responses in Phase III.

The objective had been to obtain 40 written responses. When that number had not been reached by the deadline date, all those from whom consent forms had not been received were contacted by telephone. Most indicated that they would comply, but some indicated that they had become too busy to respond. By the time commencement of the next phase of the study was scheduled to begin, 37 usable responses had been received, which was deemed adequate for the purpose. No further attempts at follow-up were made.

Initial Analysis of Responses

Written responses to the scenarios were reviewed and a content analysis completed by the investigator.

Each response was read carefully and the main themes identified. Responses were then grouped by theme for ease of discussion.

Three individuals knowledgeable in the use of the SOLO taxonomy sorted the responses into SOLO categories. Where raters differed on allocation of the response to a SOLO category, agreement between two of the three raters determined the category in which the item was placed.

Phase III

Obtaining the Sample

Phase III required the involvement of twelve nursing instructors or professors, two from each of six different institutions in the province. The Directors of the Schools of Nursing at the University Hospitals, the Royal Alexandra Hospital, and Red Deer Regional College, as well as the Deans of the Faculties of Nursing at the Universities of Alberta, Calgary, and Lethbridge were called. Each was sent a copy of the proposal, and once ethical clearance had been granted, provided me with names of faculty members with whom they had discussed the study. Each Dean or Director was asked to nominate individuals who were thought to give particular consideration to, or be particularly knowledgeable in, nursing ethics and professional values. That is, the nominees were those who were

largely responsible for teaching professional values to nursing students, and who were reflective and articulate on the topic. To protect the confidentiality of the subjects, Deans and Directors had been requested to provide several names, from which two would be randomly selected. Potential participants were contacted by telephone and the study explained; all those contacted agreed to participate. The resultant sample was 12 female professors or instructors teaching in various phases of graduate and undergraduate or diploma programs.

When the written responses had been received, arrangements were made to meet with each faculty member at her respective institution. At the first meeting the faculty member was provided with a written summary of the study (Appendix A), and her informed consent was obtained (Appendix B). She was then given copies of the 37 written responses to each scenario and asked to sort them into piles according to perceived quality, from best to worst. Each response had been numbered, and the participant was instructed to place each response into only one category. Responses to each scenario were sorted separately. There was no limitation on the number of piles or categories that could be used; the participant was merely asked to put together those responses that were similar in quality,

that is, to put all the "best" answers together, then the "next best", and so on. The participant was requested not to discuss the process with colleagues until after the sort was completed.

A second meeting was held with the faculty participant on the following day. After answering some demographic questions, the participant indicated the number of categories she had used to sort responses for each scenario, and which responses had been placed in which category. The participant was interviewed, and the interview tape-recorded. The participant chose which scenario was discussed first. She was asked, "Did you identify an ethical problem (or problems) in the scenario?" She was then asked to describe how she proceeded with the sort, and why she sorted as she did. My main interest was in determining what characteristics indicated a "best" answer to the participant, that is, on what criteria she was basing her sort. The interview was open-ended from that point; no specific interview schedule was used. Once the participant had described the characteristics of each category for the first scenario, she repeated the process for the second scenario. Again, the first question was "Did you identify an ethical problem (or problems) in this scenario?"

Analysis of data

Following completion of all interviews, category numbers for each response were entered into a computer for statistical analysis with SPSSx . Descriptive statistics, including distribution of responses by category and per cent agreement between pairs of faculty raters were tabulated. Numerical data were subjected to a latent partition analysis (LPA) (Wiley, 1967) using Scal06, a "canned" computer program designed for that purpose (Division of Educational Research Services, 1971). Data were initially unconstrained; then the program was specified to extract different numbers of clusters, until the most interpretable solution was achieved. Based on results of the LPA, the number of categories was reduced to five for each respondent; if a respondent initially had five or fewer categories, no changes were made for that individual.

Interview tapes with faculty were transcribed verbatim. Each was read carefully a number of times, and open coding begun, following the method outlined by Strauss and Corbin (1990). Individual meaning units were identified by color coding. As the purpose was to determine what various raters were using as criteria for "best" to "worst", meaning units were grouped according to quality categories. For example, all

comments describing what respondents wanted in a "best" answer were positioned together for comparison. Each meaning unit was tagged and paraphrased. Paraphrased comments were sorted and resorted as patterns emerged. Through this process of axial coding, patterns were combined and consolidated to form common themes. These themes represented the categories used by faculty respondents to evaluate the responses.

Once the common themes had been identified, the transcripts were again reviewed. Each was carefully recoded in an attempt to classify all the material according to the themes. Through this process, themes were revised and sub-categories identified, and the theoretical relevance of the identified themes was established.

Each faculty member appeared to weight the various themes differently in making a judgement about the quality of each response. The final step in the qualitative analysis of interviews was to identify how each faculty member used the various themes in her analysis. This was done largely through reflection and comparison among interviews. However, a numerical analysis was also used to assist with the process. The table of per cent agreement between each pair of faculty members was analyzed using ALSCAL, a multidimensional scaling subroutine of SPSSx (SPSSx

users guide, 1988). Four, three and two dimensional solutions were examined. A three dimensional solution was found to be most interpretable for each set of data; the dimension coordinates were then subjected to a varimax rotation using Fact16, a program designed for the purpose (Division of Educational Research Services, 1972).

CHAPTER 4: RESULTS

Phase I

Demographics

Thirty-six registered nurses were interviewed in Phase I of the study. All were employed on an adult medical or surgical unit or in an adult intensive care unit in an acute care hospital. They ranged in nursing experience from one year to more than 30 years, and had worked in a variety of settings. Nine had a baccalaureate degree in nursing; the remainder had a nursing diploma. Only four indicated that they had taken formal ethics courses. Although most indicated that ethics had been a component in their undergraduate nursing programs, some were unable to recall if ethics had been part of their basic education.

Analysis of Nurse Interviews

Interviews ranged in length from 20 to 90 minutes. Due to tape failure, two interviews were difficult to hear, and were not transcribed, leaving 34 complete interviews to be analyzed. Although the transcriptions of the interviews had yielded over 350 typed pages of text, respondents had been fairly precise in stating the nature of what to them was an ethical problem. The bulk of the text, therefore, was an elaboration on each problem, with important contextual details. In some cases, participants recalled a specific event or series

of events, which they detailed. In other cases, nurses described one or more general problems, without describing specifics of any one situation.

Each transcription was carefully reviewed, and the ethical problem statement(s) identified. The problem statements were then paraphrased in an attempt to reduce the data to more interpretable form. Examples of paraphrases of problem statements are shown in Table 4.1. Once the problem statements had been paraphrased, they were grouped into themes and sub-themes. In total, four major themes and five sub-themes were identified. Several of the sub-themes were further divided into overlapping sub-groups. Details are shown in Table 4.2.

By far the most frequently-occurring problems fell under the theme of **'preserving personhood'**. In fact, responses of nurses were remarkably consistent. In the 34 transcriptions analyzed, 27 of the nurses had defined as an ethical problem situations in which the patients for whom they had provided care were dying, and the nurses were concerned about the effects on the patient of continuing treatment when life was being prolonged beyond hope. A common theme running through the interviews was the idea that the nurse developed a bond -- a type of physical and emotional intimacy with the patient through the process of providing care over

Table 4.1 Paraphrases of Problem Statements

Text Statement	Paraphrase
whether we should let this person go on the six or eight weeks and they have no chance of or will return to a quality of life (Tape 1)	when to terminate treatment if the patient will have no quality of life
they are not fully informed and I know they're not (Tape 9)	patients don't have enough information
they keep saying they don't want to do this, and we're still giving treatment to them that involves pain and involves going against what they want to do (Tape 13)	we're continuing treatment against patient's wishes
I think really it's a big waste of money. I mean to staff a nurse for an ICU bed for a patient that's a chronic ventilator or is totally septic (Tape 11)	we're wasting money on patients who will not recover
treating my patients as a very human person (Tape 3)	maintaining patient's humanity
how afraid we are to take the appropriate action because of what we've been warned of the legal responsibilities around the patient (Tape 5)	we're not acting appropriately (ethically) because of fear of legal repercussions
but then after a while when the patients were difficult to look after, the drinkers and that, I found it really hard to have empathy for them (Tape 16)	I was having difficulty caring for certain types of patients
the patient was basically just supported for about four weeks and finally the family just let him pass away (Tape 34)	the patient was kept alive until the family could let him die

Table 4.2 Ethical problems: Themes and Sub-themes

Theme 1: Preserving personhood
- Sub-theme: Patient dignity
  - --prolonging suffering
  - --honesty and truth-telling
  - --victimization of patients
- Sub-theme: Patient autonomy
  - --informed decision-making
  - --respecting patients' wishes
  - --patient advocacy

Theme 2: Use of scarce resources

Theme 3: Nurses' rights and responsibilities
- Sub-theme: Power and powerlessness
- Sub-theme: Nurse as professional
- Sub-theme: Nurses' rights and/or interests against patients' rights

Theme 4: Cover-ups

a period of time. As one nurse put it,

> I think when you're around someone so much and you're doing incredibly intimate things with or for that person, I mean you help them go to the bathroom, you feed them, really intimate things, you get to know someone really well and it's hard to see someone you care about in pain or uncomfortable. You see what hurts them, what upsets them and what doesn't ... (Tape 25).

Nurses described a kind of empathic understanding of the patients' needs which they could sense even if the patient was unable to express those needs. They saw themselves as the persons responsible for preserving the human integrity of the patient.

In these situations, a common sub-theme was patient dignity, and the loss of dignity resulting from unnecessary and prolonged suffering. For example, one nurse indicated that the main ethical problem for her was

> ...where do you draw the line between keeping someone alive when their quality of life is really questionable. When somebody's got terminal cancer, but there's staff that say you pull them through just so they can die a slow and painful death, or somebody who is obviously is not going to get well but you plug on nonetheless (Tape 9).

Another nurse described a similar problem, in which she felt the dignity of the patient had been denied through prolonged suffering. This time a specific patient was recalled. She said:

> And he was quite young - he was only 23. At the time that he was finally allowed to die, basically all human dignity had been stripped as far as I was concerned ... he was comatose...and they were still doing everything possible to this poor fellow, and his eyes were ulcerated and you could just tell that parts of his body were rotting because of the odour ... That was sort of a big dilemma for me because I felt that they had really overstepped their bounds in terms of what is right, like when do you stop. I agree that you should do as much as you possibly can to help the patient, but there comes a time when you have to decide that you've done all that you can and there's nothing else you can do. But I just thought that he was totally dehumanized and he died a very undignified death. (Tape 11)

Respondents suggested that both doctors and nurses frequently convinced patients and/or their families to continue treatment by misrepresenting the patient's prognosis and possibility for a reasonable quality of life. In one nurse's words,

> It's not so much that they're not asked if they want treatment, I'm not so sure if we're as honest with them as we should be regarding how ill they're going to become and if they're ever going to make it out again -- just what the odds are of them coming out. (Tape 17)

Moreover, nurses were concerned that patients were often victims, in that treatment was continued for reasons other than the patient's immediate benefit. For example,

> ...along the same lines, some of the research studies that we do ... may have negative effects on the outcome of a person's health ... We've done some studies where people ...are going to torture themselves. I realize that research has to go on to progress, but there has to be some humane aspect to it all. (Tape 33)

And another said:

> Because you have to keep going for research reasons. But ethically? I don't know, I feel so strongly that we are torturing people. Many times we are torturing people for the sake of learning...(Tape 9).

Closely related to a concern with patients' dignity was the sub-theme of autonomy. The single thing that seemed to distress nurses the most was when

they were placed in a position of betraying the patients' wishes. They felt that their connectedness with the patient often made them able to intuit what those wishes were, even if the patient was unable to verbalize them. For example, as one nurse put it,

> ...and other things are kind of non-verbal things that you can tell with elderly. They give signs like sometimes people just give up and if people have given up I feel that no amount of treatment is probably going to work anyway. And I mean there's no factual or medical basis for any of these feelings, it just I guess comes down to experience ...(Tape 27)

If patients were unable to exercise their autonomy on their own, nurses felt that they had the responsibility to act as the patient's advocate. Thus, one nurse indicated that an ethical problem for her was when she was unable "... to practice the kind of care that the patient would want, to respect their rights and to stand up for their rights, to ensure that their rights are respected." (Tape 34)). Another said, "In order for you to be able to practice ethically ... you really have to know the patient and what they believe so you can stand up for them" (Tape 33).

Along similar lines was nurses' concern that patients and/or their families be fully informed so

that they could make appropriate decisions about treatment. Again and again nurses expressed their distress about the lack of understanding by patients and family making difficult treatment decisions. As one nurse described the situation in intensive care:

> they don't have any idea what suffering can be ... the patient doesn't understand what that means lying in a bed day after day having nurses look after them and turn them and move them and hurt them. They don't understand that.

Another nurse discussed the treatment of some cancer patients, noting that

> they don't really get a chance to digest the information they've heard and then think about it, find out more about it. They don't even know what it entails. I don't think they are fully informed. They are rushed into it rather quickly. (Tape 7)

A second major theme was related to **"the use (and misuse) of scarce resources".** Concerns arose with two groups of patients, the first of which was, again, those patients whose lives were being prolonged, in the nurses' view, unnecessarily. Nurses wondered about the ethics of continuing treatment when it was clear that the patient would not recover. For example,

> ...why do we bring someone into an intensive care

> unit at $1500 a day if you know they are not even going to make it out ... Because of the budget cutbacks ... we're always saying, now watch what you use ... and then we bring some lady in ... she was found basically dead ... and she was just full of maggots and everything, and it was just like a dead body. And we left her in there for two days before we pulled the plug. And I mean I feel really bad talking about money versus patient care, but ...(Tape 23).

The second group of patients that caused nurses to question was those who were being treated aggressively when their personal circumstances, such as lifestyle, made it unlikely that they would be able to comply with the required medical regimen once they were discharged from hospital. Examples were alcoholic patients who were given liver transplants although they continued to drink, or drug abusers who were treated and discharged to the community, only to be readmitted a short time later. Concern with these types of patients was not a frequent complaint, but did appear in more than one transcript.

The third major theme was **"nurses rights and responsibilities"**. Three sub-themes appeared: power and powerlessness; the nurse as professional; and nurses' safety. In the first sub-theme the problems

were, again, generally expressed in relation to dying patients. Nurses felt that their opinions with respect to decisions about continuing treatment were seldom heeded. As one nurse put it, "We have a choice to talk to the doctors and tell them what we feel or what we think, but after you're vetoed down on that you don't have a lot more ..." (Tape 13). Another said,

> One time I was doing what I thought was right, I was sort of being a patient advocate, and I was saying that what I really felt, that what we were doing to this patient was wrong ... we were just prolonging the torture ... and I was told that I didn't have the education or the background to make decisions like that ... (Tape 11)

Their close ties with the patient and family made it all the more difficult for nurses when their voices weren't heard, when "as a nurse, we know the outcome of a situation but are forced to keep going for another 24 hours and then another 24 hours. We feel for the patient, and suffer with the family greater than the physicians do" (Tape 23). One nurse expressed her sense of frustration quite vividly. She said,

> Yeah, the doctors come in and do rounds and then they go out, and they do surgery and they come back and they're maybe there for five minutes, they don't have to spend 12 hours at a time with

their patients, so they don't see it as a loss of dignity ... if they don't like what they see they can just look away. That's how they deal with it. They don't have to look after them for several hours and see that their toes are all black and falling off, they can just ignore it. (Tape 11).

Another sub-theme expressed fairly frequently had to do with **"the nurse as professional"**, and the failure of nurses to act appropriately, due to a variety of constraints. There was a strong sense that the nurse was often prevented from acting ethically because of fear of legal reprisal. For example,

> I guess when I think of ethics right now, what I'm thinking about is the clash between common sense and legality and when you do what's sensible and when you don't, and how afraid we are to take the appropriate action because of what we've been warned of the legal responsibilities around the patient. (Tape 5)

Time pressures were also a factor in nurses' behaviour.

> ...[I] was going to put the sheet over her and found that she was wet, and I was pressured, and there was a real pull to just say to heck with it ... [But] I was in one of my better ethical states yesterday. I pulled the wet stuff off, ... and went to the bathroom ... and washed this

> stuff... But there have been days when I have ... stuck her half-soiled pants in the locker and felt guilty about it and said well, I don't have time ... (Tape 3).

Also under the theme of "nurses' rights and responsibilities" was a concern for **balancing nurses' rights and/or interests against patients' rights**. One nurse described a situation in which she was required to care for patients who were verbally abusive and who threatened her with physical harm. She queried whether she should be required to provide care for these patients when she felt at personal risk, but she acknowledged that someone must care for the patient, and she felt caught in an ethical quandary. Another participant provided a detailed account of a chemically-impaired nursing colleague and the action that the nurses took to rectify the situation. Here again, the nurses had to weigh their colleague's good against the good of the patients under her care.

The final theme, **"cover-ups"**, was mentioned by only a very few nurses. They were concerned about instances of malpractice, in which the nurse was caught between protecting another health care professional, and providing full information to the patient and family. For example,

> ... when patients come in ... with normal problems

> ... and we sort of screw up somewhere and [they end up] in an ICU ward and eventually die and it's problems with what the doctors have done and a lot of doctors are aware it was a mess-up. But the families are never informed, and the nurses are told not to mention anything to the families. (Tape 10)

In summary, the themes described above were listed in order of the frequency of their occurrence in the interviews. Nurses' chief concern was that their patients not be made to suffer unnecessarily, and that their personhood be protected in the process of treatment. The use of scarce resources was an important issue, but was most often tied to the issue of prolonging treatment. Similarly, many of the concerns related to nurses rights and responsibilities were framed in the context of caring for the dying patient with limited prognosis. There were many linkages among themes, and almost without exception, the situations nurses described were extremely complex and multifaceted.

Development of Scenarios

Once the ethical problems described by nurses had been identified, the results of the analysis were used in the development of two hypothetical ethical problems a nurse might experience in practice. Attempts were

made to incorporate as many as possible of the major concerns nurses had expressed. The first scenario described the case of a patient named Mrs. Jones, the second involved a Mr. Smith. The Jones case (Figure 4.1) centred on issues related to Theme 1. In particular, aspects of the scenario touched on the patient's right to refuse treatment, and the nurse's role in seeing that Mrs. Jones' wishes were fulfilled. Although not explicit, issues pertaining to legal constraints and the nurse's rights and responsibilities were woven into the narrative. What was the nurse's responsibility given that the physician had directed her to assist him in a procedure that might be against the patient's wishes?

The scenario involving Mr. Smith (Figure 4.2) was somewhat more complex in terms of the number of facets represented. Here, the issue of prolonging aggressive treatment when the prognosis was very poor was the central problem. Relationships between nurse, physician, and family were key factors. Should the nurse provide the family with information and/or advice? The nurse's intuition and belief that the patient had 'given up' were at issue: should the nurse trust and act on that intuition? How should the nurse respond to the family's question, considering that the nurse believed the patient to be dying, and that

Figure 4.1 Mrs Jones

Mrs. Jones was an 83 year old woman hospitalized for ulcer surgery. She had severe arthritis and had been bedridden at home for over a year. Post-operatively she developed respiratory complications, which resulted in an extended stay in hospital. During her hospitalization she frequently talked to the nurses and the surgical resident about her prognosis. She indicated on numerous occasions that if her condition should worsen, and particularly if she had a respiratory arrest, that she did not want "heroic" measures to be taken. She did not wish to continue a life of pain and dependency. Her family understood her position, and agreed with her.

On May 6, Mrs. Jones was alert and oriented, and her general condition appeared to be improving. During morning care, she and her nurse, Nancy Martin, had been discussing Mrs. Jones' wishes not to have aggressive treatment. Suddenly, Nancy noticed that Mrs. Jones was having increasing difficulty breathing. She turned the oxygen on, and hurried out to the desk to call the surgical resident. The resident was in surgery and unavailable, so the nurse, recognizing the seriousness of Mrs. Jones' condition, called the attending physician. The physician did not know Mrs. Jones well, but he came immediately, and after assessing her rapidly worsening condition, called ICU for advice. The resident in ICU stated that the patient required artificial ventilation, and should be transferred to ICU. The attending physician called Nancy to assist him in intubating Mrs. Jones. Nancy complied. Mrs. Jones was intubated and transferred to ICU, where she died four days later.

Do you see an ethical problem for Nancy? Please explain your answer. Did Nancy do the right thing in assisting with the intubation? Why?

Figure 4.2 Mr. Smith

Mr. Smith, a 41 year old high school teacher, was admitted to intensive care following a motor vehicle accident. He had internal injuries, including a lacerated pancreas and ruptured spleen, and serious head injuries. Following surgery to remove his spleen and 70% of his pancreas, he was returned to ICU, where his physical condition appeared to stabilize. His neurological condition remained poor. He was comatose and responding only to painful stimuli.

Pat Jorgens, a highly experienced ICU nurse, had been looking after Mr. Smith off and on for over three months, and had been assigned to him for three days in a row. Pat noticed that Mr. Smith's physical condition was deteriorating. His blood sugars were uncontrolled, despite IV insulin. He continued to be artificially ventilated, and his blood oxygen and carbon dioxide levels were slowly getting worse. He was beginning to emit a foul odour that Pat had learned to associate with death. In Pat's words, he seemed to be "rotting from the inside out". Every movement seemed to give him pain. In Pat's experience, no patient in Mr. Smith's condition had recovered. However, aggressive treatment was continued, as the ICU staff physician felt that there was still a slim hope. Pat disagreed, but continued to do what was ordered, despite feeling personal distress.

On the third morning assigned to Mr. Smith, Pat noticed some differences in the patient's condition. Although there were no remarkable physical changes, Pat had a sense that Mr. Smith had given up the fight. In Pat's words, "I don't know how I know when a patient has given up, I just know. It comes from experience, and the intimacy you develop with a patient you've worked with for so long. I guess you could call it intuition, but I'm sure I'm right".

On this particular morning, Mrs. Smith was visiting her husband. Their two small children were in the waiting room with their uncle, Mr. Smith's brother. As usual, Mrs. Smith was allowed in to see her husband only after he was settled, so she did not have to witness any painful treatments or procedures. The nurses wanted to protect her from knowing what her husband was going through.

Later that morning, the ICU staff physician called Pat and the family together in the conference room. He told them that there still hope for Mr. Smith, but it would be a long, slow, expensive process, and there were no guarantees. The doctor wanted the family to

decide if treatment should continue. Pat felt strongly that the doctor was being overly optimistic, and in fact was giving the family false hope. The physician then left the room, and the family turned to Pat. "What would you do?" they asked.

Do you see an ethical problem for Pat? Please explain your answer. What do you think Pat should do?

continued treatment would absorb considerable resources?

When the final drafts of the scenarios were completed, they were then distributed to five experts in acute care nursing practice (two Clinical Nurse Specialists, one nurse educator, and two first line managers of hospital inpatient units). The experts were requested to review the scenarios and comment on 1. the degree to which they were reflective of typical situations in the hospital setting, that is, how "believable" the scenarios were, and 2. clarity and readability. All comments were favourable, and no further revisions were made to the scenarios.

Phase II

Demographics

Thirty-seven respondents sent written replies to the two scenarios. Of these, 17 respondents were students, 17 were practising nurses, and three failed to complete the demographic profile sheet. Students ranged in age from to 18 to 46 years (median age = 26 years), and were distributed approximately equally across the four levels of the nursing program. Graduate nurses were from 25 to 50 years old (median age = 30 years). They had from one to 20 years of nursing experience (median = five years). Six had received most of their experience in intensive care

units, six had worked mostly in medicine, and four had been primarily on surgical units. One nurse failed to complete the questions about years and area of experience.

Careful attempts had been made to protect the anonymity of respondents, so it was not possible to determine whether the answers of student participants differed substantially from those of practising nurse participants. There was, however, a wide range of responses for both scenarios.

Responses to Jones Scenario

For the scenario involving Mrs. Jones, the two questions posed to the respondents were, 1) Do you see an ethical problem for Nancy? and 2) Did Nancy do the right thing in assisting with the intubation? Responses varied in content and complexity and ranged in length from 66 to 511 words. Responses were loosely grouped into seven categories, based on their general content, as follows:

Group A: Respondents in this group did not see an ethical problem for Nancy, because to them intubation is not a heroic measure. Consequently there was no question about what Nancy should do. She was obligated as a nurse to assist the doctor in performing the procedure. There were four responses in this group, numbered 1, 12, 14, and

28. They ranged in length from 66-123 words (mean=84 words).

Group B: In this group, respondents based their answers primarily on the legal aspects of the situation. That is, they focused on whether Nancy was legally bound to carry out the physician's orders. Two subgroups emerged, depending on whether or not they saw an ethical problem for Nancy.

In subgroup B1, respondents (numbers 7, 15, 17, and 32) saw no ethical problem for Nancy because in their view Nancy had no choice to make; as a nurse, she must do as directed by the physician. Here there was little or no mention of the wishes of the patient; if these wishes were alluded to, they were dismissed as unimportant. Responses were from 90 to 177 words long (mean=128 words).

In subgroup B2 respondents felt there was an ethical problem for Nancy, in that she knew the wishes of the patient, and was being asked to go against those wishes. In other words, there was a conflict between her moral obligation to respect the wishes of the patient and her professional obligation to do as she was directed. However, again they felt that Nancy had essentially no choice in whether to assist the doctor, for

legally Nancy must follow orders. A number of respondents indicated that they felt Nancy was legally correct, but morally wrong, and that her action would be likely to cause her personal discomfort. All indicated that Mrs. Jones' decision should have been documented once it had been discussed with patient and family. This in their view would have prevented the problem from occurring. Responses in this group included numbers 2, 3, 9, 10, 11, 13, 16, 19, 21, 22, 23, 24, 33, 34, and 36. They ranged in length from 71 to 458 words (mean=213 words). Many were quite complex.

Group C: The respondents in this category (#8 and #29) indicated that they felt there was an ethical problem, as described in Group B2. In their view, Nancy should have acted differently in that she should have acted as a patient advocate by communicating Mrs. Jones' wishes to the physician. They made no specific mention of legalities and were not prepared to take a clear stand on whether or not Nancy's assisting with the intubation was ethically correct under the circumstances.

Group D: Respondents in this group were quite definite in their views. They felt that Nancy had an ethical problem in that her chief duty was to

uphold the patient's wishes, and she was being asked to betray those wishes. They all felt that Nancy was wrong in assisting with the intubation; in her role as patient advocate, she should have refused to assist the physician. None of the respondents in this group (#4, #5, #30, #31, and #37) suggested that Nancy might be legally constrained to assist with the intubation. Another response, #26, was also placed in this category because the respondent indicated that Nancy's behaviour was wrong, in that it violated the patient's wishes. However, the respondent was not sure that Nancy perceived an ethical problem, because information was not available as to Nancy's feelings on the subject. Answers ranged in length from 79 to 382 words (mean=168 words).

Group E: There were two responses in this category (#18 and #20, at 197 and 245 words, respectively). These respondents identified the ethical problem as a possible conflict with Mrs. Jones' wishes, but they were not sure what Nancy's views were on the subject, so could not determine if Nancy would perceive a problem. One respondent suggested that the right thing to do would be to honour the wishes of the patient, but if Nancy felt she was helping the patient by assisting with the

intubation, then it was the right thing to do. The other respondent said, "Given the assumption that Nancy would opt to be an advocate for Mrs. Jones, she would be unable to accompany the attending physician during the act of performing the 'heroic' measures". This response was, however, contingent on the assumption that Nancy accepted that role; otherwise, there was no conflict for her.

Group F: There was only one response in this category (#35, 112 words in length). This respondent indicated that it was difficult to determine if there was an ethical problem for Nancy, because "There was no mention if the doctors or nurses asked Mrs. Jones if she wanted to be intubated. If she did, then that would solve Nancy's predicament". However, if Nancy knew that Mrs. Jones did not wish to be intubated, then Nancy was wrong in assisting the physician.

Group G: The three respondents in this group (#6, #25, and #27) all saw a problem for Nancy, but felt that she was right in assisting with the intubation. They assumed that Nancy held sanctity of life as a paramount value, and they felt that her personal values should guide her actions. These answers ranged in length from 123-523 words

(mean=319).

Variations in length were a result of respondents elaborating on their answers to various degrees. A number of factors entered into the discussions. Several respondents were concerned about Nancy's right to refuse to assist the doctor, and what ramifications such refusal would have, while some were adamant that Nancy must stand up for Mrs. Jones' rights, regardless of the consequences. A few participants discussed the 'right to die' issue, equating non-participation by Nancy with passive euthanasia. A variety of solutions were offered, most in the realm of prevention: Nancy should have worked to ensure that Mrs. Jones' wishes were communicated to all concerned with her care. The most prevalent response was that the problem could have been prevented had there been a 'Do Not Resuscitate" order on the chart.

Responses to Smith Scenario

Questions posed in the Smith scenario were 1. Do you see an ethical problem for Pat? Please explain your answer. 2. What do you think Pat should do? Again, respondents were divided as to whether or not there was an ethical problem for Pat, how the problem should be defined, and how Pat should react. These responses were somewhat difficult to divide into content groupings, as the respondents' positions seemed

less clear-cut than for the Jones scenario. Whereas in "Jones", participants were asked to evaluate the actions of the nurse, in the Smith scenario they were asked what the nurse should do. Therefore, responses to Smith were phrased more in terms of action than in terms of the ethical problem as such. For Jones, how the respondent defined the ethical problem seemed to determine judgment of the nurse's action; for Smith, the relationship between problem definition and acceptable action was less clear. People may have defined the ethical problem in different ways, while coming to the same conclusion about what the nurse should do. However, responses could be loosely grouped according to the respondent's definition of the ethical problem, as follows:

Group A. The four respondents in this group (#15, #27, #28 and #36; 108-241 words, mean 173 words) felt that there was no ethical problem for Pat because his/her course of action was clear; Pat should report his/her observations to the family, and then let the family make the decision.

Group B. In this group (#10, #17, #22, #31, #32, #33), respondents failed to comment on whether they perceived an ethical problem for Pat. They did, however, recommend action. All but two individuals (#10 and #31) felt that Pat should not

tell what she/he felt about the patient's prognosis, but rather should reinforce what the doctor had said. The other two felt that Pat should tell "facts", not feelings, about the patient's condition. Answers in this group ranged in length from 59 to 272 words, with a mean length of 153 words.

Group C. The one respondent in this category (#19, 141 words) suggested that the situation was difficult and would **feel** as if an ethical problem existed. This respondent felt Pat should not contradict the doctor, but should inform patients that they had the right to another opinion.

Group D. All respondents in this category (#6, #25, #29, and #30) felt there was an ethical problem for Pat, but failed to define the nature of the problem. Answers were quite simple, varying in length from 73 to 130 words, with a mean of 90 words. Respondents were in agreement that Pat should give family members the information they wanted, but the nature of this information remained undefined.

Group E. In this group of three (#2, #11, #26; 120-297 words, mean 223 words), respondents saw an ethical problem, which they defined in terms of differences in perspective (that is, a **care** versus

a **cure** orientation) between medicine and nursing. Two respondents felt the nurse should communicate to the family what she/he felt about the patient's prognosis, while the third individual felt the nurse should support what the doctor had said, regardless of whether their two opinions differed.

Group F. The ethical problem for these respondents was framed in terms of uncertainty about what to tell the family. #5 (118 words) failed to answer the question about what Pat should do, while #34 (185 words) indicated that "In no way should [Pat] offer her personal opinion", but should present the family with "facts" about the patient's condition. Conversely, #12 (112 words) felt that Pat should "explain to the family what I would do and how I feel based on my experiences".

Group G. In this category, respondents defined the ethical problem as one of deception of the family. Respondents #7, and #9 indicated that Pat should clarify what had been said to the family, to ensure that they had sufficient information to make a decision. Respondents #21 and #24 felt that the nurse should involve the family in caring for the patient, so they could see for themselves how the patient was suffering. Answers in this

group ranged in length from 171 to 432 words, with a mean of 275.

Group H. This was the largest category, including ten responses (#1, #3, #4, #8, #14, #16, #18, #23, #35, #37). They tended to be quite complex, and ranged in length from 137 to 315 words, with a mean of 220 words. Members of this group defined the ethical problem in terms of conflict; the nurse's opinion conflicted with the doctor's. Respondents were generally in agreement as to what the nurse should do; most felt Pat should keep his/her opinions quiet, as the family should not be made aware of disagreements among health care professionals. In other words, they wanted the nurse to preserve an appearance of solidarity. One respondent, however, felt Pat should present the nursing perspective in the interests of ensuring that the family was fully informed.

Group I. The lone respondent in this category (#20, 219 words) defined the ethical problem in terms of a difference between what the nurse believes the patient would want and what the doctor wants for the patient. This respondent put the emphasis for action on working with the family to determine what the patient would have wanted under the circumstances.

Group J. This respondent (#13, 243 words) suggested that Pat would have an ethical problem only if she/he allowed emotions to interfere with actions. Pat should, in this person's view, involve the family in the patient's care, and if questioned directly, tell the family what he/she would do if it were his/her family member.

Again, there was a range of complexity in the responses. Some, having identified a central ethical problem, described or identified a variety of facets that would (or should) impact on the action of the nurse. Therefore, in constructing their answers, respondents varied as to which aspects of the scenario they considered salient. Some concentrated on the nurse's experience and considered whether intuition was a valid source of knowledge about the patient's condition. Others focused on what they called deception of the family. A very few were concerned about the economics of the situation, and fewer still mentioned the age of the patient as an important variable. The relationship between doctor and nurse was important to most respondents, and was frequently translated into an issue of solidarity among members of the health care team.

In stating what the nurse should do, participants again varied in the complexity of their responses.

Some were fairly simplistic, suggesting that only one course was open to Pat, as "there is nothing Pat can do except reiterate what the doctor has said ... legally Pat is bound to do no more" (#33). Others, by contrast, suggested a number of things Pat could do in the situation, such as communicating his/her observations and beliefs about the patient to the doctor, exploring the family's feelings, and giving the family as much information as possible. Although most agreed that Pat should not give advice per se, they were divided as to whether Pat should offer an opinion (based on experience and intuition) about the patient's prognosis. Almost all respondents (34 out of 37) emphasized that the family must make the decision, and that the nurse was only to provide information and support. The differences in responses rested largely on what constituted valid information, and what the nurse could freely communicate to the family.

Phase III

Demographics

In Phase III, faculty members sorted the responses described above according to perceptions of quality, along a continuum from best to worst. A total of 12 faculty participated in the study. Four of these had a baccalaureate degree, six had a Masters degree, and two had a doctoral degree. Two of those with Masters

preparation were engaged in doctoral studies. Four participants had taken formal ethics courses; four had taken philosophy courses with some ethical components; and four had no formal ethics training. Participants had from five to 30 years teaching experience, and had taught in a wide variety of courses. Clinical specialties ranged from maternal/child to intensive care to community health. None of the participants had taught ethics as a formal course, but all had taught ethics as part of nursing courses.

Participants were asked how long it took them to sort the responses; one individual reported that it took her two and one half hours to sort, but she would have liked to have had more time; the remainder reported taking from four to six hours to complete the task.

Analysis of Jones Data

Numerical Analysis

In sorting responses to the scenario involving Mrs. Jones, faculty used from four to 11 categories. Table 4.3 shows the range of categories and the modal category into which each of the written responses was placed. In the table, "item" represents individual written responses, numbered 1 to 37. Category 1 represents "best" answers, thus, the higher the number, the lower the perceived quality of the response. It

Table 4.3 Range of Category Placement and Modal Placement for Each Response to Jones Scenario

Response	Category*		
	Low	High	Mode
1	1	8	4,7
2	2	8	4
3	2	10	2,4
4	1	5	2
5	2	11	2
6	1	8	5
7	2	8	4
8	1	7	1
9	2	10	4,5
10	2	7	4
11	1	8	1
12	1	8	4
13	2	4	4
14	1	8	7
15	2	9	4,7
16	1	4	1
17	2	8	4
18	1	4	2
19	1	7	1,3

Table 4.3 continued

Response	Category*		
	Low	High	Mode
20	1	7	3,4
21	1	5	3
22	1	7	2
23	1	6	3
24	1	5	1,2
25	2	7	2,4,5
26	1	7	2
27	1	7	2
28	1	8	4
29	2	9	2,3,4
30	1	5	1,3,4
31	1	4	1
32	1	8	2,4
33	2	8	4
34	2	7	2,3
35	2	10	2,3
36	2	6	2
37	1	7	1

*Note: High numbers denote lower quality. "Best" responses are category 1.

can be seen from the table that none of the responses was sorted into the same category by all faculty members. The range of responses is particularly interesting; some responses were rated in the "best" category by some faculty members, and in the "worst" category by others.

To determine the degree of congruence between faculty members in how they sorted the responses, a per cent agreement was calculated for each pair of faculty members. An agreement was scored each time both members of the pair placed a response in the same category. Results are shown in a stem and leaf display in Table 4.4 (uncollapsed). The range of per cent agreement was 3 to 51, the mean was 18, and the median was 16.

The variation in number of categories used by different faculty members made comparison difficult, and it was decided to collapse categories to facilitate comparison and discussion. Wiley's (1967) latent partition analysis (LPA) was conducted to determine the optimal number of categories. Details of the analysis and results are shown in Appendix E. The results of the LPA (Table E.1) suggest that there were five quality categories underlying the observed sorting. Consequently the categories in the faculty sort were collapsed into five, using the following procedure. If

Table 4.4 Stem and Leaf Display of Percent Agreement Between Faculty Pairs on Placement of Responses into Categories (Uncollapsed and Collapsed Categories)-- Jones Scenario

---

Uncollapsed

```
0: 3
0: 5 5 8 8 8 8 8 8 8 8
1: 1 1 1 1 1 1 1 1 1 1 1 1 4 4 4 4 4
1: 6 6 6 6 6 6 6 6 9 9 9 9 9 9
2: 2 2 2 2 2 2 4 4 4
2: 7 7 7 7 7 7 7 7
3: 0 2 2
3: 5 5 5
4:
4:
5: 1
```

Collapsed

```
0:
0: 8 8 8 8
1: 1 4 4 4 4 4 4 4 4 4
1: 6 6 6 6 6 9 9 9 9 9 9
2: 2 2 2 2 2 2 2 2 2 4 4 4 4 4 4 4 4
2: 7 7 7 7 7 7
3: 0 0 0 0 0 2
3: 5 5 5 8 8
4: 1 1 1
4: 6 6 9
5: 1
```

a faculty member had used only four or five categories in her original sort, it was left unchanged. To determine which categories should be collapsed together for the remaining faculty members, transcripts were read carefully and the respondents' comments used as a guide. For example, if a faculty member indicated that there were few differences between items in the last four categories, those categories were collapsed into one. The end result of the collapsing process is shown in Table E.2 of Appendix E. Even after categories were collapsed there was little agreement among faculty members as to how the items should be ranked in terms of quality. This is reflected in the stem and leaf display of percent agreement between faculty pairs for the collapsed data (Table 4.4) Although the per cent agreement among faculty members was slightly higher on the collapsed categories than the uncollapsed categories, it was still very low, ranging from 8 to 51, with a mean of 24 and a median of 22.

The frequency with which each response was placed in each category is shown in Table E.3. in Appendix E. To make it easier to identify "best" and "worst" items, categories were further collapsed into three (Table 4.5). The top two categories were added together to make a "best" group; category three was left unchanged, and categories four and five were grouped together.

Table 4.5 Categorization of Items into Best, Middle, Worst, SOLO, LPA, and Content Categories -- Jones Data

Item	Quality Category: Best (1&2)	Middle (3)	Worst (4&5)	Content	LPA	SOLO*
22	9	2	1	B2	II	Rel
11	8	1	3	B2	IV	EA
18	8	3	1	E	II	Rel
37	8	2	2	D	IV	EA
8	7	2	3	C	IV	Multi
16	7	3	2	B2	IV	Rel
19	7	4	1	B2	IV	Rel
24	6	4	2	B2	II	MR
27	6	1	5	G	IV	EA
13	2	7	3	B2	III	Multi
34	3	6	3	B2	III	Rel
15	1	0	11	B1	V	Uni
12	2	0	10	A	V	Multi
28	2	0	10	A	V	Uni
1	2	1	9	A	V	Uni
6	3	0	9	G	IV	Multi
9	3	0	9	B2	III	Multi
14	2	1	9	A	V	Uni
25	3	1	8	G	II	Uni
10	2	3	7	B2	III	Rel

Table 4.5 continued

Item	Quality Category: Best (1&2)	Middle (3)	Worst (4&5)	Content	LPA	SOLO*
17	1	4	7	B1	III	Uni
33	2	3	7	B2	III	Uni
7	1	5	6	B1	III	Multi
20	4	2	6	E	IV	Multi
29	4	2	6	C	II	Uni
35	3	3	6	F	I	Uni
3	5	3	4	B2	III	Rel
4	5	3	4	D	I	Multi
5	5	2	5	D	III	Uni
26	5	3	4	D	II	Multi
30	5	3	4	D	I	Uni
32	5	4	3	B1	II	Multi
36	5	4	3	B2	II	Multi
2	4	5	3	B2	III	Rel
21	4	5	3	B2	III	Rel
23	4	5	3	B2	IV	Rel

*Note: SOLO categories: Uni=unistructural; multi=multistructural; rel=relational; EA=extended abstract; MR=multistructural to relational transitional.

Items were then ordered according to how they were placed by the majority of respondents. That is, those items that were placed in the "best" category by at least six respondents were listed first, followed by the "middle" and "worst" groups. Those that were sorted more or less evenly into the three categories were listed last. The fifth column, "Content", indicates into which of the seven content categories (A to G, as described on pp. 76 to 81) each of the 37 responses fell. The column labelled "LPA", indicates the cluster into which the item was placed on LPA. These clusters are taken from the results shown in Table E.1 in Appendix E.

From this table, it is evident that opinions varied considerably on the quality of most items; only on items 15, 12 and 28 were faculty in strong agreement. The LPA categorization reveals that the "best" items were in categories four and two, while the "worst" were mostly in three, four and five. There was little relationship between content category and LPA categorization, or between content category and classification of quality as best or worst, with one exception. All items in LPA category five (1, 12, 14, 15, and 28) were in the "worst" category; these items were all in content category A or B1. That is, they were answers in which the respondent failed to see an

ethical problem for the nurse.

The inconsistent relationships between content category, LPA category, and perceived quality suggest that faculty members used a variety of criteria when evaluating the responses. One factor that might have influenced perception of quality was the structure or complexity of the responses. To explore that possibility, three raters knowledgeable in the SOLO taxonomy (Biggs & Collis, 1982) (see p. 36, above) discussed and rated the responses according to SOLO criteria. Item placement in a SOLO level required agreement of at least two of the three raters. Results of the SOLO rating are shown in the last column of Table 4.5.

Again, there is little pattern in how items were sorted according to SOLO structure. Items in LPA categories I or V, which were the two "cleanest" categories in that they showed little overlap with other clusters, were mostly unistructural, and there was substantial content consistency in these two clusters. However, LPA categories II, III, and IV showed considerable overlap with other categories, and contained items from all content categories and with all levels of SOLO structure.

Clearly, the evaluation of responses involved a complex interplay of factors. Numerical analysis

revealed few identifiable patterns that would be helpful in determining what underlying criteria faculty were using in determining which were "best" and "worst" answers. It was hoped that analysis of interview transcripts would uncover those criteria. Faculty had been asked to describe why they categorized responses as they did. However, here again, responses were indeterminate. In a number of cases, the actual placement of items in categories appeared inconsistent with what was said by the faculty member. Closer examination of the transcripts did, however, yield a pattern that suggested a form of consistency.

Qualitative Analysis of Interview Data

Structural considerations

As faculty members described what they liked and did not like in the various responses, it became clear that they were approaching the question from two angles. One entailed the consideration of structural elements corresponding to those described by Biggs and Collis (1982). That is, faculty members were looking at the complexity of the response, its logical coherence, and the identification and appropriate use of relevant features of the scenario. One faculty member put it succinctly,

> I was really looking for ... the delineation of the data, the consideration of the fact that there

> were a number of grey areas involved in this particular situation ... basically looking for the reasoning and the complexity of reasoning. (Faculty 8, p. 4).

Faculty looked at whether the respondent "gave comprehensive reasons for the decision that [she] made (Faculty 6, p. 2)" and "...brought in ... some of the thinking, some of the background material ... so it was very easy to see and follow through just exactly how she had arrived at the decision ... (Faculty 4, p. 9)." These features were described by some faculty members as evidence of critical thinking. The individual's ability to articulate his or her position clearly was also a consideration, for

> there had to be a certain flow - I had to understand what I was reading. And sometimes when you didn't understand what you were reading you lost the ability to identify whether it was an articulate or an appropriate response. Or if you had to read it three or four times, saying "I think this is what the person is saying" - that influenced where they got fitted, compared to someone who was clear and articulate. (Faculty 5, p. 16)

As well, faculty considered the extent to which the individual went beyond the data presented, (a criterion

for an extended abstract response in the SOLO taxonomy), either in a search for more information, or in suggesting a resolution to the problem. For example, in describing a "better" answer, one faculty participant said,

> ...she didn't limit it to the immediate situation - she looked at the immediate intubation and the attending physician - she went back into ICU as well ... and then she followed through on her actions. And she tried to resolve - to find some answers to it. But she also looked at the context ... (Faculty 5, p. 12-13).

However, structural elements were not the only aspects considered, for if they had been, none of the unistructural or multistructural responses would have been classified in the "best" category, and all the extended abstract responses would have been rated consistently at the top. What seemed to be "confounding" the evaluation of responses was the personal viewpoint of the reviewer with regard to the substantive content. That is, each reviewer reacted to the scenario in a unique way according to her own value system. The interviews revealed a complex interplay of values and beliefs influencing how the reviewer rated each response. This is described below in terms of an interpretive framework.

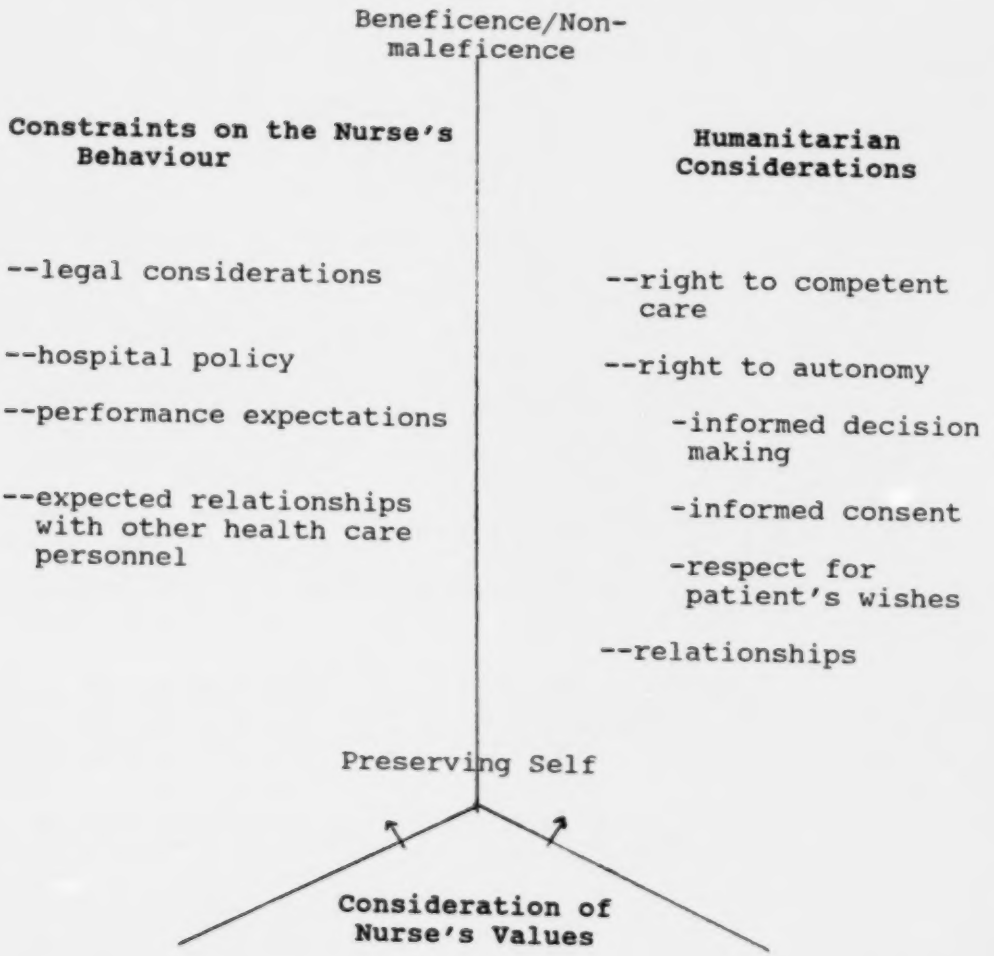
Interpretive framework

Again, in-depth analysis of the interview transcripts involved a process of line-by-line coding and paraphrasing. Paraphrased statements were grouped together to form themes and sub-themes, which represented features that faculty had identified in the responses. These themes, modelled in Figure 4.3, served as the basis both for the respondent's written answers and the faculty evaluation of those answers. Faculty appraised the respondents' recognition of and reaction to the various facets of the model, and accordingly made their judgements about the responses.

The first theme, **"Constraints on the nurse's behaviour"**, referred to factors related to the nurse's position as a professional within a hierarchical system. Expectations inherent in that role could be presumed to influence the nurse's perception of the problem and subsequent behaviour. They included legal considerations, hospital policy, expected relationships to other health care professionals, and performance expectations.

"Legal considerations" were related to whether the nurse (Nancy) had a legal obligation to assist the physician. It was noted that many of the respondents "felt that the legal responsibilities took precedence over the ethical ones (Faculty 4, p. 6)." One faculty

Figure 4.3 Framework for Evaluation of Ethical Problems -- Jones Scenario



member indicated that it was possible to judge the action of the nurse in the scenario "as being both correct and incorrect depending on whether you looked at it ethically or legally (Faculty 10, p. 6)", and she noted that "legality tended to form a distinguishing element for me as well when I was sorting through the answers (Faculty 10, p. 6)."

"Hospital policy", as a "Constraint", was closely tied to legal considerations. Here it was noted by faculty that "we have a hospital policy - most of us - have to initiate what's written on the chart (Faculty 5, p. 11)". Thus, policy discussions centred on what might (and should) have been charted, and how the nurse should act in the absence of a physician's order.

Another "constraining factor" was "expected relationships of the nurse to other health care professionals" (notably physicians). Should the nurse follow the physician's orders without question? Consideration was given by faculty to respondents' views about the position of the nurse in the hospital hierarchy. For example, one faculty member defined an important aspect of the responses as being recognition of

> ... some sort of conflict between being a patient advocate for Mrs. Jones and also the duty to work as a team member and to ... be a part of a team

that works toward saving lives (Faculty 1, p. 5). Another considered how nurses might respond in view of the fact that as Nancy

> didn't question at all what the doctor was doing ... [she] either agrees with this course of action or she feels powerless in the situation to do anything about it. And I think this is a very real scenario (Faculty 12, p. 20).

Therefore, in her "best" responses, this faculty member wanted some consideration of how the hierarchical structure might influence the nurse's behaviour.

The sub-theme of "performance expectations of the nurse" was related to the belief that the nurse has an obligation to provide competent care, **as defined by the profession**. Consequently, definitions of competent care vis-à-vis definitions of "heroic measures" played an important part in these discussions. Other aspects of performance expectation were related to whether it was the nurse's responsibility to ensure that Mrs. Jones' wishes were communicated to all members of the health care team, and whether it was up to the nurse to obtain a "Do Not Resuscitate" order from the physician.

The second major theme was labelled **"Humanitarian Considerations"**. On this side of the model the emphasis was patient-centred rather than nurse-centred, and included aspects referred to in Phase II as

"preserving personhood". Thus, the focus was on patient rights, such as the "right to competent care" and the "right to autonomy", and on interpersonal interactions, or "relationships". Elements of informed decision-making, informed consent, and respect for the patient's wishes were subsumed under the sub-theme of autonomy. Woven throughout the main theme were considerations of patient dignity, and the nurse's role as advocate.

The "right to competent care", is, of course, linked to the nurse's obligation to provide care. When viewed from the "patient's rights" side of the model, however, competent care may look somewhat different. One distinction is that on this side of the model, "competent care" is defined, in large part, by the patient (and/or the family), not the nurse. Nurse's and patient's definition of competent care may (or may not) be quite different. For example, a number of respondents felt that intubation was an essential comfort measure for the patient, and therefore the nurse was obligated to assist with the procedure. By contrast, others believed that Mrs. Jones had included intubation in her definition of "heroic measures", and that to Mrs. Jones, **not** assisting with the intubation would be an indication of competent care.

The "right to autonomy" is central to a

consideration of patient rights. The Code of Ethics for Nursing (Canadian Nurses Association, 1991), holds as a key value the respect for client choice. The Code states, "Based upon respect for clients and regard for their right to control their own care, nursing care reflects respect for the right of choice held by clients" (p. 3). In the situation represented in the scenario, the question of autonomy centred on whether or not Mrs. Jones had the right to choose not to have the proffered treatment (intubation), and whether those wishes must be respected by the health care team. As one faculty member put it, "autonomy was the key ... the individual's right to decide what happens to them (Faculty 11, p. 11)". Respect for autonomy involved "the concept of informed decision making -- the idea That [Mrs. Jones'] decision had been made at a time when there perhaps weren't a lot of other factors infringing on the situation (Faculty 10, p. 2-3)".

A close parallel to informed decision making was informed consent. In this context, the question was raised as to whether Mrs. Jones knew what intubation involved, and whether or not she consented to the procedure. If not, "by going ahead with the intubation when she knows it's without consent ... it's against the wishes of the patient, and, indirectly would be against the wishes of the family because they knew and

understood (Faculty 7, p. 2)".

Respect for the patient's wishes, then, involved acting on behalf of the patient to ensure that the patient's decisions were upheld. Here the idea of advocacy was especially important; the nurse was seen as having a responsibility to act as a "voice" for the patient within the system. Considerations of patient dignity also emerged. To many respondents, the nurse was seen as having an obligation to ensure preservation of the patient's dignity within the alien hospital environment.

"Relationships" seemed to play an essential role in some nurses' contemplation of the ethical problem. For the most part, this concern was framed in terms of the relationship of nurse with patient, and the obligations such relationships impose on the nurse's behaviour, particularly in terms of advocacy. The argument was that the nurse, by virtue of close contact with the patient, might have information that others do not have, and it is the obligation of the nurse to communicate or act on this information. This is exemplified in the comments of Faculty 7, who said,

> I felt that ... there should have been congruence through there - that, having engaged in the conversations, having understood Mrs. Jones' decision of "no heroics", **that** was the attitude

she should have taken to the physician when calling for immediate attention (Faculty 7, p. 2).

Linking the two conceptual domains of "constraints" and "humanitarian considerations" were the constructs of "beneficence" and "protecting self". Beneficence was in essence the overarching, or umbrella, concept, insofar as the general goal was to act in the patient's best interests. Thus, the nurse had to balance patient rights with professional expectations in the interests of "doing good" for the patient, (and, conversely, "doing no harm"). As one faculty member put it, the role of the nurse is "to be of benefit, to not harm patients" (Faculty 1, p. 6). At the same time, the nurse's decisions could be influenced in part by a need to protect his/her own self interests, for in this case, "she could have refused to assist with the intubation but may have lost her job or been severely reprimanded as a result (Faculty 12, p. 22). Consequently, the desire to "do good" might be offset by a perceived need to protect self, with the result that the nurse's action might not be in the best interests of the patient.

The third major theme was **"consideration of the nurse's values"**. This reflected the individual nurse's knowledge, attitudes, and beliefs, which would influence understanding of and response to both

constraints and humanitarian considerations. The nurse's value system would determine whether he or she perceived an ethical problem. It would also have an impact on the nurse's interpretation of the patient's rights, and of what would be beneficent versus non-maleficent. For example, in one response "[the nurse's] feeling of preserving life and putting life in God's hands took precedence over what [Mrs. Jones] believed (Faculty 12, p. 26)". As well, the nurse's value system would influence whether, in this situation, it was more important to protect "self" or "patient".

Effect of personal values on evaluation

Personal values appeared to dictate how respondents reacted to the scenario, that is, how they evaluated Nancy's behaviour, and what they thought Nancy should have done. As well, values also had a great impact on how faculty members viewed the responses. That is, personal values influenced not only what respondents wrote, but also how faculty evaluated the written answer. Thus, personal values determined how faculty members weighted each of the facets of the model in determining what would be a "best" response. Values also governed how tolerant faculty were of ethical positions that were different from their own. Interestingly, faculty held quite

different ethical perspectives from one another, and were divided on which of the factors were most important, and how much impact they should have had on respondents' decision-making.

The effect of personal values is reflected in the fact that faculty members were not in unanimous agreement as to whether or not an ethical problem existed for the nurse in the scenario. All agreed that there were ethical dimensions to the scenario, and that these revolved around the possibility that the nurse was betraying the patient's wishes in assisting with the intubation. However, Faculty 1 and Faculty 5 did not see an ethical problem in the situation itself, because they felt the nurse's course was obvious; she must assist with the intubation, because

> our ethical dilemma is over-ruled by the legalities ... there might be some personal distress ... maybe a minor ethical issue, a minor concern. But ...professionally she didn't have a lot of choice anyway (Faculty 5, p. 11).

Thus, from their perspective, the "Constraints" part of the model was dominant. Faculty 9 felt there was no ethical problem in the actual situation because in her view intubation is not a "heroic measure", so Nancy was not going against the wishes of the patient. This faculty member appeared to feel that Nancy's obligation

lay primarily in providing competent care, as defined by the nurse. All three faculty members who stated they did not perceive an ethical problem for Nancy agreed that there had been a problem, but that it had happened much earlier. As Faculty 9 put it,

> I think the dilemma came in for me in how the whole situation happened. And that the family wasn't there and the attending physician didn't know these things. So I guess that part was an ethical dilemma but not the actual "what the nurse did", but looking at the whole process of how come the family physician didn't know if this woman had actually said this so many times. And that was what I think bothered me more.

The views of Faculty 4 and Faculty 6 were similar; they felt there was an ethical problem for Nancy, but they emphasized that it could have been avoided. As Faculty 4 indicated

> I thought there was an ethical problem ... but I think that the way in which most of the people saw it, and I tended to concur with them, ... was the ethical problem was there before the situation occurred - and the situation had to deal more with the legalistic problem than the ethical problem (p. 1).

Again, these individuals placed considerable emphasis

on the "Constraints" aspect of the situation.

Faculty who were most influenced by "Constraints" tended, in evaluating the written responses, not to be particularly concerned with

> the actual issues of the "shoulds" and the "coulds", [but] to look at it from a perspective of the comprehensive way in which people dealt with this - understanding both the ethical and the legal factors and pulling those together (Faculty 4, p. 2).

That is, this group of faculty appeared to be tolerant of a variety of viewpoints. Faculty 6 noted, "what I was looking for was really, not whether they agreed with me or not as to whether there was an ethical problem, but **how** they explained their own answer (p. 1)". Thus they were concerned, not so much with specific content, but with the complexity of the response and/or its logical development, that is, with what were essentially structural elements. Consequently, simple statements that there was no ethical problem because "intubation is not a heroic measure" were ranked highly by some members of this group because the answers were logically coherent.

By contrast, some faculty members were definite in their view that there was an ethical problem for Nancy, and that her obligation was to ensure that Mrs. Jones'

wishes were respected. Their values, then, were decidedly on the side of humanitarian considerations. However, they varied in their tolerance of differing viewpoints. Faculty 8, indicated, "I was actually quite amazed that some people thought there wasn't any dilemma. I suppose that came out in terms of my sort because those people were the ones that basically - I placed dead last (p. 1)." Faculty 8 also wanted "recognition of other points of view...the fact that there is more than one perspective ... and recognition of the complexity of the situation and the number of variables involved (p. 2)". Faculty 2's "best" respondents "recognize[d] that actually helping in the intubation procedure would be unethical. That ...nurses must act ethically - they put the patient first ... (p. 2)." In her "best" responses, Faculty 7 wanted the client's wishes to be "taken as being paramount (p. 4)" and, and she wanted recognition "that [Nancy] had failed to protect the patient's rights and respect her wishes - therefore she was ethically wrong (p. 4)".

Others in the group that emphasized humanitarian considerations were concerned that respondents recognize an ethical problem, but they did not demand that "best" answers involve a judgement of Nancy's action as wrong. In describing her own feelings about

the scenario, Faculty 12 stated,

> [Nancy] did let Mrs. Jones down and for me this was unethical. I'm not sure whether Nancy saw it the same way ... Nancy did what she felt she had to do - and that's fine given her path - it didn't seem that there was any problem for Nancy to follow through - even though I disagree with what she did do (p. 19).

Therefore, in selecting "best" answers, Faculty 12 allowed for varying conclusions, suggesting that "these were the best answers in the complexity and the different areas that they considered but I didn't always agree with their rationale (p. 21)". In these "best" answers respondents had also "really looked at the ethical principles here of autonomy ... versus beneficence and nonmaleficence...(p. 20)". Similarly, Faculty 11 wanted consideration of ethical principles and evidence of "an ethic of care". This she defined as

> responsibility of the nurse, and it really was her obligation to act as an advocate for the patient who wasn't able to communicate herself ... the role of the nurse in relation to caring ... more than just support and communication, but really doing something with those, and ... taking those extra steps to make sure that the patient's

concerns are addressed - the patient's needs.

For Faculty 3, the ethical problem was "that basic conflict of nurse knowing and going with what she knows for the patient's best interests and being loyal to the medical profession (p. 17)". She "felt very sad that [Nancy] complied in terms of her knowing the patient well - knowing what she wanted", and in her "top" category she wanted respondents to acknowledge that assisting with the intubation was an ethical problem, and that patient autonomy was important. However, she also wanted recognition of the legal constraints, and a discussion of how the problem could have been prevented.

Finally, Faculty 10 was not sure if there was an ethical problem or not. Nevertheless, for her the "best" responses made reference to "autonomy, informed decision making, importance of communication, dialogue, - not only with the patient and family but also with other health team members as well (p. 4)". Answers in her lower categories tended to place emphasis on the legal aspects of the situation.

In summary, faculty members held widely different viewpoints on what constituted a "best" answer to this ethical problem. Individual knowledge, attitudes, and beliefs resulted in apparently different moral outlooks for each individual, and determined how

responses would be rated on a quality continuum. Each of the faculty members gave consideration to all the themes and sub-themes mentioned in the interpretive framework. What varied among faculty was the weight that they gave to each facet. Their personal viewpoints about the ethical situation seemed to have an important effect on what they defined as salient features of the scenario, and what action would be appropriate for the nurse in question. This appeared to make a substantial difference, at least for some faculty members, in how they classified the responses.

There were, however, some similarities among respondents. Those faculty who considered evidence of critical thinking and logical coherence as their most important criteria appeared to lean toward the "constraints" side of the interpretive framework. That is, they were more sympathetic to responses in which the nurse relied on legal and policy restrictions to guide decision-making. They wanted evidence of reasoning skills and application of principles and rules. This seems somewhat suggestive of a "justice" orientation, as described earlier in this paper.

By contrast, a number of faculty were strongly inclined in the direction of "humanitarian considerations". They were most interested in seeing evidence of respect for the patient, and they wanted

the respondent to describe an advocacy role for the nurse. They were also concerned about the nurse-patient relationship and the implied contract between patient and nurse. These faculty seemed to place a high value on responses that might reflect an ethic of care.

Multidimensional Scaling

The distinctions between "care" and "justice" perspectives were, however, far from definitive. It was felt that multidimensional scaling might help to uncover patterns underlying faculty decision-making about quality of responses. Consequently, percent agreements among faculty (collapsed categories) were entered into the computer and subjected to multidimensional scaling (MDS).

Interpretation of the output of the MDS program proceeds much as in factor analysis; one looks at the projections of clusters on axes and at a "goodness of fit" index called "stress" to determine how many dimensions underlie the data. Stress indicates how closely the data fit the spatial or dimensional model; lower stress shows better fit. With the percent agreement data, the most interpretable result, based on projections and minimum stress, indicated that three dimensions provided the best portrayal of agreement among faculty. The three-dimensional solution yielded

a stress of 0.11, which suggests a moderate fit. The squared multiple correlation coefficient was 0.84. Results of the MDS are shown in Figure 4.4.

In MDS, as in factor analysis, the solution is useful only if the researcher can name the dimensions. In this case, a tentative naming of the dimensions rested on the interview data. Based on the comments of faculty members, and their spatial relationships identified by MDS, the first dimension appeared to represent a "humanism" versus "rules" continuum. This is consistent with the distinction between "humanitarian considerations" and "constraints" as defined in the interpretive framework (Figure 4.3). The second dimension was possibly "complexity", and the third was "logical coherence". These two dimensions seemed to be tied to the structural evaluation of the scenarios. There was, however, no clear separation of faculty members according to anything comparable to a "care-justice" dichotomy. The MDS served primarily to confirm that the surface pattern of faculty evaluation of responses to the Jones scenario was very complex and unlikely to lead to a simple, universal continuum of "good-bad".

In conclusion, analysis of the Jones data revealed that the way in which a response was ranked by a faculty member was determined, not by a defined

Figure 4.4 Relative Spatial Locations of Faculty Members as Determined by MDS* -- Jones Data

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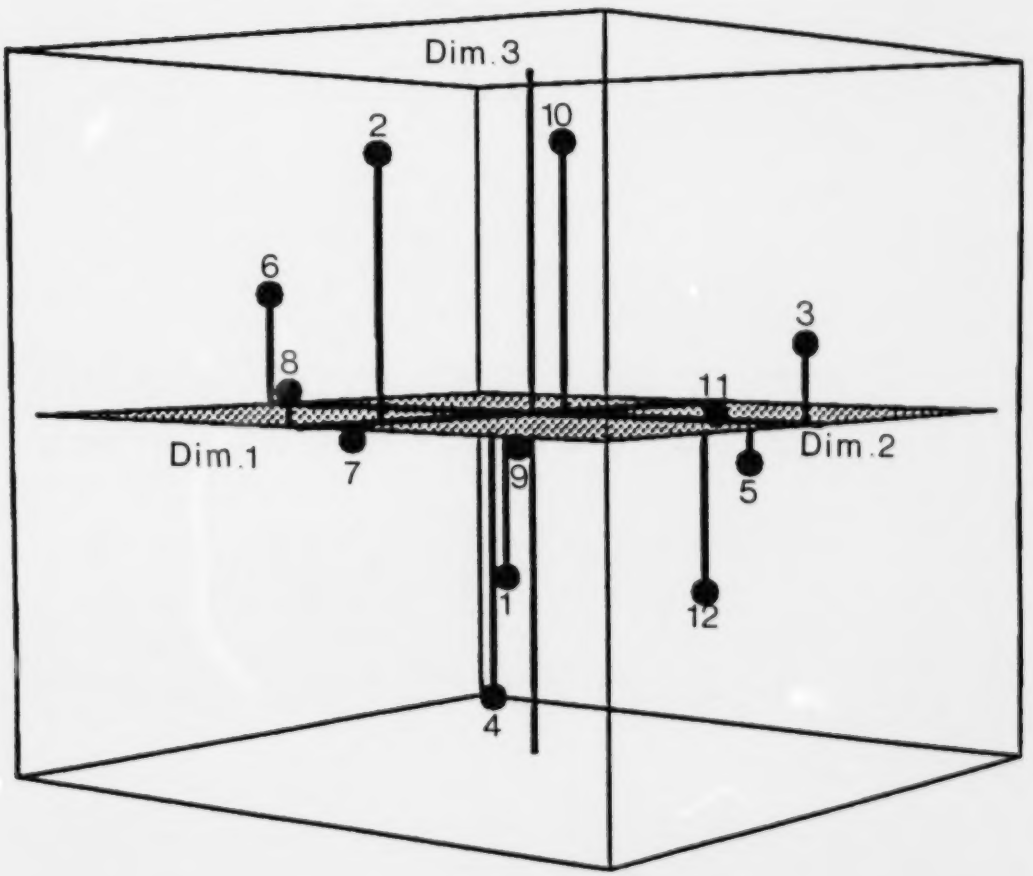

professional standard, but by the personal characteristics of the individual reviewer. Each faculty member brought to the task a set of knowledge, attitudes, and beliefs that determined an acceptable balance of professional obligations and humanitarian concerns with respect to the need to "do good" for the patient, while at the same time protecting self. The framework shown in Figure 4.3 appeared to serve all faculty members for this scenario. The data for the scenario regarding Mr. Smith will now be examined, with the particular objective of determining the relevance of the interpretive framework (Figure 4.3) for decision-making in this second situation. That is, an attempt will be made to apply the interpretive framework in the context of the Smith data to determine if the model is useful as an explanatory tool.

Analysis of Smith Data

Numerical Analysis

As with the Jones data, faculty had differing viewpoints about the quality of the responses to the Smith scenario. They sorted the answers into from four to twelve categories. Table 4.6 shows the range of category placement (uncollapsed) and the category into which each item was placed most frequently. Again, it can be seen that none of the responses (items) was placed in the same category by all faculty

Table 4.6 Range of Category Placement and Modal Placement for Each Respose to Smith Scenario

Response	Category*		
	Low	High	Mode
1	1	6	3
2	2	11	4
3	1	4	2
4	1	10	1,2
5	2	12	6
6	2	12	3
7	1	5	3
8	1	8	1
9	1	6	1
10	1	5	3
11	1	8	2,3
12	2	12	3
13	1	8	3
14	2	11	3,5
15	1	12	3
16	1	10	4
17	2	10	4
18	1	4	1
19	1	8	4
20	1	3	2

Table 4.6 continued

Response	Category*		
	Low	High	Mode
21	2	8	4
22	1	5	2
23	1	5	2
24	1	7	1,2
25	2	12	5
26	1	7	3
27	1	9	1,4
28	1	5	4
29	1	12	4,5
30	1	9	3
31	2	9	3,4,6
32	2	10	4
33	4	12	4
34	1	5	2
35	1	12	3
36	1	7	1,2,3,4,6
37	1	4	2

participants, and all responses showed a considerable range. This is further evidenced by the stem and leaf display of per cent agreements among faculty, shown in Table 4.7. The range in per cent agreement for the uncollapsed Smith data was 0 to 33, the mean was 18.3%, and the median was 19%.

To make the data more interpretable, an LPA was conducted on the faculty categorization (see Appendix F). Based on this analysis it was decided to collapse the categories on the Smith data into five. The process for collapsing was similar to that followed with Jones data; faculty interviews were used to determine which categories could be combined. The end result of the collapsing process is shown in Table F.2 of Appendix F. Again, there was little agreement among faculty on placement of items, and most items were placed in a wide range of categories (Table F.3, Appendix F). Per cent agreement (Table 4.7) increased somewhat with collapsing; the range was from 3 to 59%, with a median of 23% and a mean of 23.7%. Interestingly, faculty pairs who were in greatest agreement on the Jones data were not necessarily in agreement on the Smith data.

As with the Jones data, three individuals rated the Smith responses according to SOLO criteria (Biggs & Collis, 1984). The SOLO category for each item was

Table 4.7 Stem and Leaf Display of Percent Agreement Between Faculty Pairs on Placement of Responses Into Categories (Uncollapsed and Collapsed Categories)--Smith Scenario

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Uncollapsed

```
0: 3 5
0: 6 8 8 8 8 8
1: 1 1 1 1 1 1 1 1 1 4 4 4 4 4 4 4 4
1: 6 6 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9
2: 2 2 2 2 2 2 2 2 2 2 4 4
2: 7 7
3: 0 0 0 0 0 0 2 2 2 3
3:
4:
4:
5:
```

Collapsed

```
0: 3 5
0: 8
1: 1 1 1 1 4 4 4 4
1: 6 6 6 6 6 6 9 9 9 9 9 9
2: 2 2 2 2 2 2 2 2 2 2 4 4 4 4 4 4 4 4
2: 5 7 7 7 7 7 7 7
3: 0 0 0 0 0 0 2 2 2 2 2
3: 8 8
4: 1 4
4:
5: 4 9
```

determined by agreement of at least two out of three raters. SOLO categorization of the Smith data revealed that the largest number were multistructural, whereas in the Jones data, the largest group was unistructural. However, there were no extended abstract responses in the Smith data, compared with three extended abstract answers for Jones.

To make interpretation easier, quality categories were further collapsed into "best", "middle", and "worst". The quality categories are compared with LPA, Content, and SOLO categories in Table 4.8. In the table, items that were rated as "best" (categories one and two) by six or more faculty members are listed first, then those in which the majority placed them in category three, then those that were rated "worst" (categories four and five). Items that were not placed in any one category by six or more faculty are listed last. This table reveals some consistency between quality category and LPA category. All items in the "best" category were in LPA categories I or II. Content shows some consistency as well; most of the items in the best category are from content categories G or H, whereas the B and D responses are almost all in the "worst" group. However, content categories were also related to length; the responses in category G were generally quite long and complex, which might

Table 4.8 Categorization of Items into Best, Middle, Worst, SOLO, LPA, and Content Categories -- Smith Data

Item	Quality Category Best (1&2)	Middle (3)	Worst (4&5)	Content	LPA	SOLO*
37	11	0	1	H	I	Rel
18	11	1	0	H	I	Rel
20	10	2	0	I	I	MR
9	10	1	1	G	I	Rel
22	10	1	1	B	I	Rel
8	7	2	3	H	II	Rel
3	7	3	2	H	I	Rel
7	7	2	3	H	II	MR
11	6	5	1	E	II	Multi
24	6	3	3	G	I	Multi
34	6	4	2	F	II	Multi
19	4	6	2	C	II	Multi
26	3	6	3	E	V	UM
35	2	7	3	H	III	Multi
28	2	6	4	A	II	Multi
33	0	1	11	B	IV	Uni
5	2	1	8	F	IV	Uni
14	1	3	8	H	II	Uni

Table 4.8 continued

Item	Quality Category Best (1&2)	Middle (3)	Worst (4&5)	Content	LPA	SOLO*
17	1	3	8	B	IV	UM
25	1	3	8	D	V	Uni
31	1	3	8	B	IV	Uni
32	1	3	8	B	III	Multi
6	1	4	7	D	IV	Uni
15	2	3	7	A	II	Multi
29	2	3	7	D	V	Uni
2	2	4	6	E	II	Multi
27	4	2	6	A	IV	Multi
30	2	4	6	D	IV	Multi
4	5	3	4	H	III	MR
10	4	5	3	B	III	MR
13	5	4	3	J	I	Rel
16	4	4	4	H	II	Multi
1	4	5	3	H	IV	Uni
12	4	3	5	F	V	Multi
21	3	5	4	G	II	MR
36	4	4	4	A	IV	Multi

*Note: SOLO categories: rel=relational; multi=multistructural; uni=unistructural; MR=multistructural/relational transitional; UM=unistructural/multistructural transitional

indicate that faculty were responding to complexity, as much as to substantive content. This is supported by the SOLO categories; "best" responses are all multistructural or relational (or multi-relational transitional).

These results are similar to those with the Jones scenario in the sense that both content and structure appeared to influence decisions about the quality of responses. This shows beginning support for the interpretive framework found with Jones data. There is evidence that a number of factors were working in faculty decision-making, and that each faculty member responded somewhat differently to the scenarios, defining acceptable answers in diverse ways. Consequently there was little agreement among faculty as to the quality of responses. Again, personal characteristics of the reviewer seemed to be the defining factors for decisions about quality.

To examine the data for spatial relationships, percent agreements among faculty members were again analyzed using a multidimensional scaling routine. A three-dimensional solution yielded a stress of .12 and a squared multiple correlation of 0.83, indicating a fairly good fit of the data to the model. The coordinates of the three-dimensional solution were then subjected to a varimax rotation. Results are shown in

Figure 4.5. The MDS did little to reveal patterns underlying faculty evaluation of responses. In fact, the solution was such that no attempt to name the dimensions proved satisfactory. What the MDS plot did show is that, in comparison with the Jones data, individuals shifted positions relative to one another. For example, Figure 4.4 shows Faculty 7 and Faculty 8 close together on all three dimensions, whereas in Figure 4.5 they are widely separated on dimension two, and somewhat distant on dimension three. This of course reflects the fact that different faculty members were in agreement with one another across the two scenarios. Apparently, disparate factors were at work in faculty's evaluation of responses to the two scenarios.

Another comparison between Jones and Smith data is shown in Table 4.9. In this table, aggregate ratings for each item in terms of "quality" (best, middle, worst, even) and "structure" (SOLO levels) are shown for the two scenarios. The table reveals that individual respondents produced answers of varying quality and structure for the two scenarios. For example, respondent #9 produced an answer rated in the "worst" category for Jones, and in the "best" category for Smith. The structural complexity of this respondent's answers ranged from multistructural to

Figure 4.5 Relative Spatial Locations of Faculty Members as Determined by MDS* -- Smith Data

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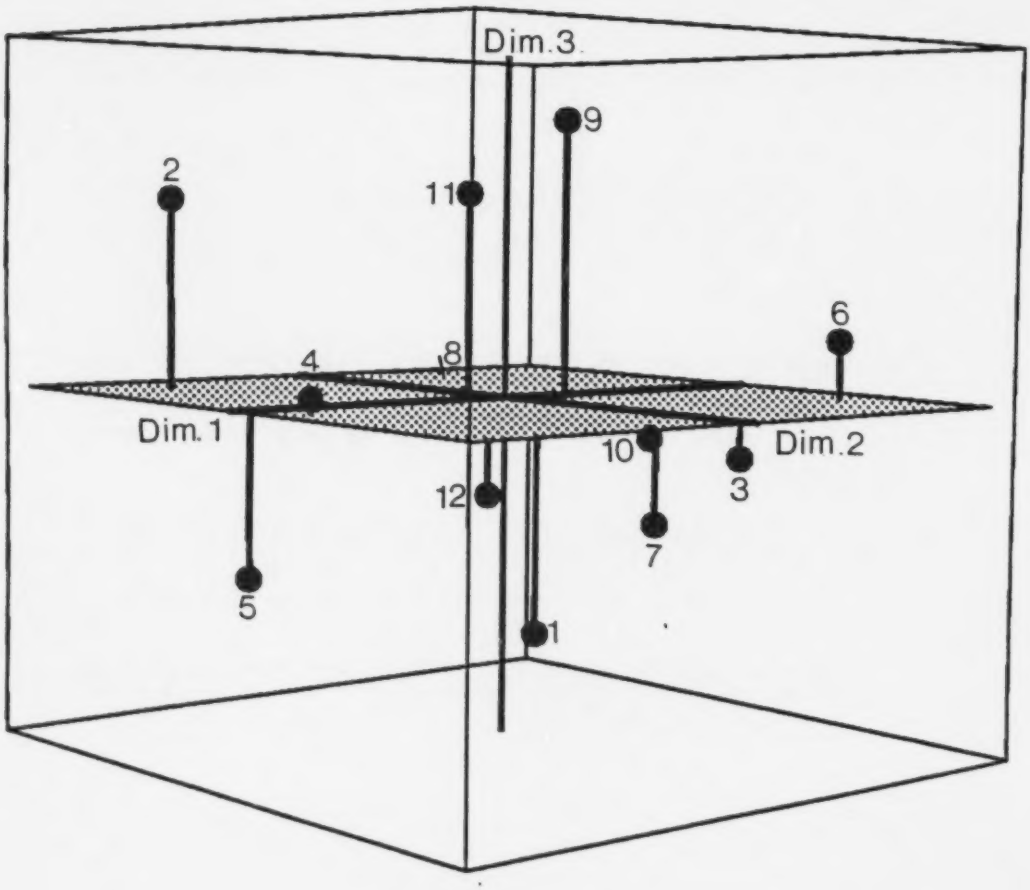


Table 4.9 Comparison of Jones and Smith Data on Quality Category and SOLO Category

	Quality Category		SOLO Category	
Item	Jones	Smith	Jones	Smith
1	Worst	Even	Uni	Uni
2	Even	Worst	Rel	Multi
3	Even	Best	Rel	Rel
4	Even	Even	Multi	MR
5	Even	Worst	Uni	Uni
6	Worst	Worst	Multi	Uni
7	Worst	Best	Multi	Multi
8	Best	Best	Multi	Rel
9	Worst	Best	Multi	Rel
10	Middle	Even	Rel	MR
11	Worst	Best	EA	Multi
12	Worst	Even	Uni	Multi
13	Middle	Even	Multi	Rel
14	Worst	Worst	Uni	Uni
15	Worst	Worst	Uni	Multi
16	Best	Even	Rel	Multi
17	Worst	Worst	Uni	UM
18	Best	Best	Rel	Rel
19	Best	Middle	Rel	Multi

Table 4.9 continued

Item	Quality Category		SOLO Category	
	Jones	Smith	Jones	Smith
20	Worst	Best	Multi	MR
21	Even	Even	Rel	MR
22	Best	Best	Rel	Rel
23	Even	Best	Rel	MR
24	Best	Best	MR	Multi
25	Worst	Worst	Uni	Uni
26	Even	Middle	Multi	UM
27	Best	Worst	EA	Multi
28	Worst	Middle	Multi	Multi
29	Worst	Worst	Uni	Uni
30	Even	Worst	Uni	Multi
31	Best	Worst	Uni	Uni
32	Even	Worst	Multi	Multi
33	Worst	Worst	Uni	Uni
34	Middle	Rel	Rel	Multi
35	Worst	Middle	Uni	Multi
36	Even	Even	Multi	Multi
37	Best	Best	EA	Rel

Note: SOLO categories: EA=extended abstract; Rel=relational; multi=multistructural; uni=unistructural; MR=multistructural/relational transitional; UM=uni/multistructural transitional

relational. Overall, only 14 of 37 respondents wererated in the same quality category by the majority of faculty for both scenarios, and only 11 of 37 achieved the same SOLO level. Moreover, moving from aggregate to individual data, it can be seen that faculty rated respondents differently on the two scenarios (compare Tables E.2 and F.2). For example, Faculty 1 rated respondent #11 in category 1 for Jones and in category 3 for Smith. Clearly, there were differences across the two scenarios. Either faculty were using a different rating scale, or respondents' quality of answer varied, or both. Results indicate that, as the interpretive framework suggests, responses are triggered by a complex interaction between values and situation. To examine further the nature of this interaction, attention is turned next to the interview transcripts.

Qualitative Analysis of Interview Data

When they were interviewed, faculty were asked to describe separately their rationale for sorting responses for Jones and Smith. A comparison of the two portions of each interview showed that structural elements such as clarity and logical coherence, described as important in evaluation of responses to the Jones scenario, were also important for Smith. For example, Faculty 1 was impressed by an answer that was

"well written, very articulate", and was "very well thought out ... was really able to give rationale for what she would do". Similarly, Faculty 5 was concerned with "understandability of the response - could I understand what they were saying?" Such considerations were, however, mentioned less frequently for Smith than for Jones, possibly because they had already been mentioned in discussions of Jones. Instead, in evaluating responses to the Smith scenario, faculty concentrated on their evaluation of substantive content per se. Again, what was perceived as "quality" content differed widely among participants, and it was clear that many factors were being taken into account. When the evaluation framework identified in the Jones data was used to examine faculty discussions about Smith, an interesting difference between the two scenarios emerged.

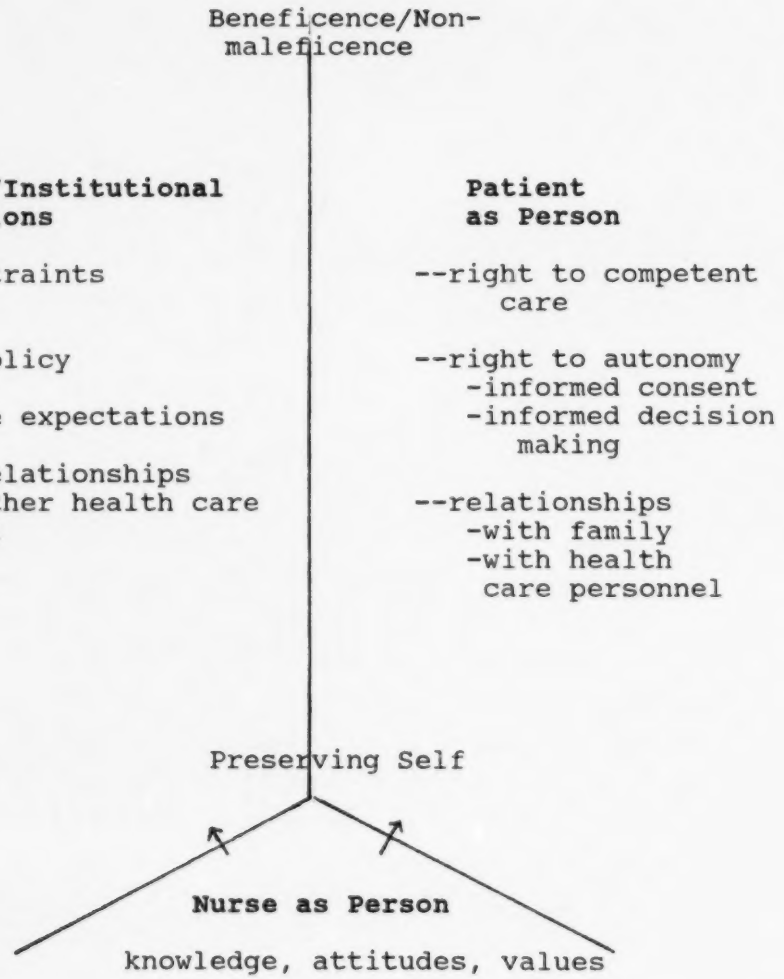
With Jones data, it was fairly easy to separate "constraints" from "humanitarian considerations", perhaps because the action of the nurse (assisting with the intubation) was concrete. It seemed to be a relatively straightforward decision for most respondents as to whether the action was right or wrong. For the majority, evaluation of the nurse's action was predicated on beliefs about what the nurse was expected to do on the basis of legal and policy

requirements. When humanitarian considerations played a part in decision-making, they seemed to be quite distinct from other constraints.

By contrast, with Smith the respondent was required, not to pronounce upon an action already taken, but to generate a description of desirable action on the part of the nurse. Respondents' decisions about what the nurse's action should be, and faculty evaluation of such decisions, was guided less by formal rules and regulations than by personal understanding of the professional responsibility of the nurse. How this responsibility was defined and interpreted appeared to involve considerable interplay among facets of the model. Responses to the Smith scenario seemed to demonstrate in particular the close connections between the nurse's values, humanitarian considerations, and expectations inherent in the role of nurse. The observed differences between the two cases, and the emergence of some new elements, resulted in a reworking of the framework and a renaming of the identified themes. The new themes subsume the old, as they are more broadly encompassing. The renamed themes are **"Professional/Institutional Obligations"**, **"Patient as Person"**, and **"Nurse as Person"**, as shown in Figure 4.6.

In the Smith data, it was evident that

Figure 4.6 Revised Interpretive Framework



considerations of "patient as person" were closely tied in with definitions of "obligations". How the link was made seemed to be highly dependent on personal characteristics of the nurse. Therefore, the first theme to be discussed here is **"Nurse as Person"**. With the Jones data, the theme related to personal characteristics of the nurse was focused on consideration of the nurse's values. With the Smith data, it became evident that, as Rokeach (1979) has suggested, knowledge and attitudes are also influential in shaping behaviour. This emerged in the discussions about whether or not an ethical problem existed in the scenario. Five faculty (#1, #5, #6, #9, and #12) felt there was no ethical problem in the situation because what the nurse should do was quite obvious to them. For Faculty 9, the conclusion was based on knowledge resulting from practice, for she " had experiences with some things related." Faculty 12 had also had "a fair degree of ICU experience", and "was just going with my own experience" (p. 1), while Faculty 1 indicated that her rationale

> ...goes back to my own background in ICU and the number of years that I worked there, that these type of conditions or situations would come up (p. 2).

Faculty 5 based her opinion on a more general

knowledge. She noted that

> Because of accountability and responsibility - it was fairly clear to me how she should proceed within the defines of nursing (Faculty 5, p. 2).

For Faculty 6, the decision that there was no ethical problem was based on attitude or belief. In her view,

> ...it's not your responsibility to say what you think - what you think is not relevant ... as far as the family were concerned - it's not for her to say "No, I think this patient is dying", or what she would do is not important - it's what the family wants to do that's important (Faculty 6, p. 9).

Those faculty who did not perceive an ethical problem for themselves did acknowledge, however, that there might be an ethical problem for someone who had less experience, or was less sure. As Faculty 12 put it,

> I think that a lot of nurses would see this as an ethical problem if they had not grown in terms of their confidence level - in terms of seeing themselves as a valuable team member capable of contributing valuable information (p. 3).

Thus, the definition of ethical problem was seen as being closely tied in with the nurse's background. In general, this group of faculty wanted to see evidence

of knowledge and experience in the respondents' answers. For example, Faculty 5 noted that, "One of the reasons I liked her - she had some knowledge coming through here - in terms of the family and stress (Faculty 5, p. 3)". Faculty 12, in explaining how she chose her "best" responses, indicated

> The reason I chose the first ones was because I didn't see an ethical problem for Pat because that is how I would see my role as a nurse in an ICU setting ... so these answers I picked generally because they were similar to my own (p. 2).

This similarity to her indicated experience and knowledge of the situation.

The position of faculty who perceived an ethical problem in the situation (Faculty #2, 3, 4, 7, 8, 10, and 11) was similar in that they saw various ethical dimensions to the problem, and acknowledged that the nurse's experience might impact on her response. However, they were less certain that the nurse's action was obvious. They tended to question what the nurse **could** know about the patient

> recognizing that her own thoughts and feelings were based primarily on intuition and knowing that within the profession there still isn't ... a great deal of credibility accorded to the role of intuition (Faculty 10, p. 8).

Thus, the question of what is a valid source of knowledge for nursing emerged from these discussions. The role of intuition, which is firmly rooted in the concept of "nurse as person", was variously accepted. For example, Faculty 10 indicated that

> I personally believe that intuition is very valuable - an experience itself - and ... those respondents who accorded no importance or credibility to intuition - I tended to rate as poorer than those that said "Yes this is valuable information that the nurse does need to share in some way..."(p. 7).

Another gave lower ratings to respondents who

> saw the nurse's experience as being less valid - it was more emotions, or feeling - that kind of thing ... when I say "experience" I'm talking about Pat's intuition, her sense based on her experience ... so in the first category, the best category, they recognized that as being valid (Faculty 2, p. 15).

On the other hand, some faculty in this group did not consider intuition as important. For instance, Faculty 3 indicated that

> ...that didn't enter in - how people were valuing or not valuing ... her intuitive ability - didn't play into where they fell in this (p. 15).

Instead, this faculty member placed emphasis on the respondent's

> sensitivity ... the attentiveness ... to a question of value. And that there wasn't a recognizing of grey - that it was black and white. ... And if that wasn't there, that immediately put them down in the bottom for me. ... I looked for [the ability to] identify what the problem was - ... and there were a number of different ones that I accepted as legitimate (Faculty 3, p. 3).

Similarly, Faculty 4 was less concerned with a specific definition of the ethical problem, and was more interested in whether or not the nurse could recognize the complexity of the problem. She noted,

> Some of them saw it very simplistically ... and others saw it in terms of a problem that related to nursing, in relationship to communications, in relationship to ethics, in relationship to the family, in relationship to a whole lot of information processing. And to me ... the better ones understood the full dimensions of the problem ... (p. 10).

This faculty member, after much pondering, eventually decided to rate responses

> in relationship to two types of scaling. One related to the dimension of the problem and the

> other related to the nurse's role (Faculty 10, p. 4).

However, understanding of the "full dimensions of the problem" and the "nurses role", involved other aspects of the framework.

The second theme identified in the Jones data was "constraints on the nurse's behaviour". With Smith, the emphasis appeared to be more on obligations than on constraints, and the theme was relabelled **"Professional/Institutional Obligations".** As with Nurse as Person", the new theme subsumes the old, for "constraints" are inherent in "obligations". Faculty 5 provided an example of the concern with obligations. For her, respondents with "best answers"

> were ... able to identify the roles and the responsibilities of the individuals involved. Not just of the registered nurse, but the family members or the individuals ... looked at the actions and functions of the nurses in terms of task oriented or compassionate - the balance there ... [and] commented upon the accountability to respond to the legal situations of the nurse (p. 1).

The "action" question posed in the Smith scenario was "What do you think the nurse should do?". This was interpreted by respondents and faculty as "What, if

anything, should the nurse tell the family?" Again, the answer to this question required considerable interplay with other themes. The definition of "roles and responsibilities" was highly dependent on the individual nurse, and his/her knowledge, attitudes and values. While one or two respondents suggested that the nurse's course was defined by legal considerations, that is, that "legally the nurse could do no more" than reiterate what the doctor had said, faculty in general dismissed that idea. Instead, they seemed to be in agreement that the nurse had an obligation to provide the family with some information beyond what the doctor had afforded. However, they were divided on the nature of that obligation. Discussion involved several considerations, but focused primarily on what the nurse should tell the patient. Part of the problem was related to what was considered legitimate information, as discussed above. Was intuition a valid source of knowledge? To Faculty 7,

> part of the role of the nurse [is] to clarify the meaning of medical things ... the nurse I felt had that role to represent what she saw in the patient (p. 20).

Along corresponding lines, Faculty 4 noted that

> ...you can start really identifying just exactly whether or not they see communications with the

> family as just being a reiteration ... [some] see it as a simple problem, but their communication is based on giving information that is already given - in other words, they elaborate on the information but it's something that's already there - they're not doing anything or adding anything - any dimensions to it (p. 11).

The question was, what "extra dimensions" should be included? In the view of Faculty 5, it was "additional information of facts", whereas Faculty 10's "best" respondents "would also be quite willing and open to share their views and their experience and how they were feeling about the situation" (p. 9). To Faculty 12, "intuition does play an important role in the care of the client" and should be shared with the family.

The lack of clarity on exactly what the nurse's responsibility to the patient/family entailed is exemplified in the remarks of Faculty 3. In her opinion, "...the patient deserved to know what information [the nurse] was picking up because she had been caring for him (p. 1)", but then

> I thought of that as my own value, and I put that aside and then I thought "of course not - that is something that's in the CNA Code of Ethics - it is something that's now been brought into the patient's rights and responsibilities in the

> States, and for many years we looked at some of those ethical issues as being not right or wrong but individual and some of those - now I do believe are a nurse's responsibility (p.2)".

Although the bulk of the discussion regarding "obligations" was centred on the responsibility of the nurse to the family, there was also some consideration of the role of the nurse vis-à-vis the physician. A number of respondents had defined the ethical problem as being one of conflict between nurse and physician, but faculty tended to see it, not as a question of conflict, but as a question of relationships. Faculty 7 suggested that

> the biggest ethical decision or dilemma I saw here was the nurse's silenced behaviour in not communicating effectively to the doctor. I guess her not taking a strong enough nursing stand to say "these are the things I feel"...(p. 19).

To her, respondents who

> ...didn't value their own opinions enough or ...would be silenced by the power difference or whatever - I thought they didn't have as clear of an understanding of what nursing was and what the nursing relationship to the client was (p. 21).

On the issue of whether the nurse should be seen to disagree with the doctor most faculty were concerned

with the implications open disagreement would have for the family. They felt that the nurse could talk to the physician, as "collegial relationships need not necessarily be controversial, confrontational" (Faculty 10, p. 13). However, they questioned whether that should happen in front of the family in stress, "because at this point in time, perhaps that isn't something the family needs to see ...) (Faculty 10, p. 13). The worry was that

> what might be established here is a sense that there's disunity amongst the ranks - it may shake [the family's] faith. Or it may adversely affect their ability to make a decision. There's more at stake here than just credibility ... (Faculty 8, p. 21).

Moreover, there was concern with how the physician might be affected. As Faculty 8 put it,

> In some of the best answers, there was more concern, for example, shown for the physician and where he might be at and considerations given to "If I confront him, or contradict him, then what does that do, not just for the physician, but what does that do for the family?" (Faculty 8, p. 19).

Thus, issues of relationships among health care professionals were considered in more depth, and were closely tied to considerations of the needs of the

family.

One of the things that seemed to make it difficult for both respondents and faculty to define the responsibilities of the nurse was that the definition was enmeshed in considerations of **"Patient as Person"**. In this situation, "patient" included "family". As with the Jones scenario, there was much discussion about the nurse's role as advocate, and what advocacy in this situation entailed. Several faculty defined the ethical problem in terms of autonomy, that is, as "the right of the family to decide what to do. And the extent to which the physician or nurse should try to influence their decision"(p. 1). One issue in this regard involved whether or not the nurses in the scenario had been deceptive in not allowing the family to see the patient until he was settled. Although there was acknowledgement that nurses might be attempting to protect the family, to some it was clearly a misguided effort. In the words of Faculty 7

> the other big ethical problem was the deception that the nursing staff had kept up by only presenting sort of the glossy picture of a settled patient in a bed ... so many of the players were paternalistic throughout it ... the nurses, I thought, were as wrong in how they presented the patient as the doctor was in giving false hope (p.

20).

Faculty 11 expressed similar concerns. She wanted respondents to consider

> issues relating to honesty on the one side of the coin - or deception on the other side of the coin. Were they being honest if they weren't letting the family members see what he was really like. On the other hand, were they intentionally withholding information? And if she didn't pass on information to the family, would she be deceiving them, would she be honest? (p. 2)

Examination of the Smith data revealed a sub-theme under "Patient as Person" that had not been as readily apparent in Jones. This sub-theme, "Relationships", involved the patient's relationship with family/significant others, and with health care professionals, particularly the nurse. Family relationships were strongly evident in this scenario, probably because it was the family who consulted the nurse. Most of the discussion regarding advocacy centred on the family, and how the nurse could help the family make the decision, but there was also concern that the rights of the patient himself be protected. Thus, considerations of the right of the family to make decisions for the patient could be placed under this sub-theme. For example, Faculty 7 gave lower ratings

to responses that

> made the family seem like they had the autonomous right, regardless of what they knew or didn't know about the client's wishes. That he was sort of already written off for dead ... made it seem like it was up to the family and the doctor (p.22).

Similarly, Faculty 10's "best" respondents "would ask the family what they thought Mr. Smith would want under these circumstances" (p. 9).

"Relationships" of patient/family with the nurse were evidenced in a variety of ways in this discussion, although they were implicit, rather than explicitly stated. All faculty and almost all respondents agreed that it was the responsibility of the nurse to support the family in their decision-making, but not try to tell them what to do, for it was "definitely a family decision". It was assumed that the nurse would develop a trusting and open relationship with family members, such that they would feel free to ask the nurse's advice and counsel. Another area in which "relationships" surfaced was in discussions about intuition. There seemed to be a tacit understanding that the nurse's intuition evolved largely through close contact with the patient - that in caring for the patient the nurse developed a kind of empathic understanding and knowledge of the patient. Such

knowledge, "even though you can't quantify it (Faculty 12, p. 5)", is nonetheless important.

In summary, discussions regarding the Smith scenario were, if anything, even more complicated than those regarding Jones. Faculty considered what would constitute the most favourable balance among a number of conflicting demands. Questions of "Who is harmed?" "Who benefits?" "What is the role of the nurse? doctor? family?" were examined from many angles. Answers to these questions tended to reflect very personal beliefs and values of faculty members, and each faculty member accorded a different degree of importance to particular aspects of the responses. For example, Faculty 3 listed her main criteria for "best" answers as being 1. recognition of an ethical problem, 2. sensitivity to the complexity of the problem, 3. a valuing of patient choice, and 4. presentation of alternatives for the nurse. For Faculty 2

> the best responses acknowledged a bigger role for nurses. They acknowledged that the nurse's experience in ICU was valid, was important and was sort of worth hearing about. They also all talked to the family, and they also would encourage the family to make the final decision (p. 14).

For Faculty 9, the issue of first importance was communication. She wanted respondents to acknowledge

that the nurse was not to express an opinion, but rather must tell **facts**. Communicating with the doctor and "letting him know how you felt", and providing the family with as much information as possible were central. Whereas Faculty 12 picked "best" responses on the basis of their similarity with her own view that there was no ethical problem, Faculty 11 noted that

> whether I agreed with the person or not, the better responses were the ones that more fully addressed the issues that were coming out of the case. So not so much whether I agreed with them or not or whether they fit with my own ethical thinking, but more, did they realize what issues were there to be considered? (p. 4).

Thus, although there was some agreement about what was important, or what the "answer" should be, there was certainly no consensus. These observations serve to emphasize the complexity of decision-making with regard to ethical questions in a clinical setting, and point to the need for increasing discussion on the subject.

The interpretive framework extracted from the various attempts to respond to and evaluate two composites of ethical problems facing nurses provides a structure for this discussion. The framework demonstrates that the tension between professional/institutional obligations and recognition

of the patient as a person must be addressed within each nurse's own configuration of professional knowledge, experience and personal moral development.

In the following chapter, these ideas will be expanded, and their implications for nursing ethical theory and for ethics teaching and evaluation examined. Literature from moral theory, nursing and medical ethics, and developmental psychology, will be brought to bear on the discussion in an effort to establish a sound conceptual base for future research and theory development.

CHAPTER 5: DISCUSSION

In its original conception, this study seemed to be a fairly straightforward process: nurses would be interviewed, scenarios representative of common ethical problems created, and a generic "best" response to these scenarios developed on the basis of the collective judgment of experienced nursing faculty. This best response could then be used as a kind of template against which a student's ethical thinking could be evaluated. It was reasoned that, although it is probably not possible to measure a student's moral reasoning on, for example, a scale of one to six (cf. Rest, 1987), it might be possible to determine if, over the course of a nursing program, a student was moving closer to an established goal. The purpose of this study was to establish that "goal".

However, the lack of consistency and widely differing viewpoints among faculty members made this undertaking unsuccessful. There was simply no agreement on what would be a best response in the two problem situations. Thus, instead of being straightforward, the results leave one with a feeling of having wandered into a conceptual minefield, where cherished notions of validity in measurement, and of the "structure" of ethical thinking, seem about to explode.

The study lends support to some recent conceptualizations of nursing ethics as being more than, or different from, principled reasoning about what one "ought" to do in a given situation. At the same time, it suggests that our understanding of the nature of nursing ethics is far from complete, and it raises many interesting questions about how one can learn to be more "ethical" in a clinical context, and how the extent of that learning can be assessed.

The emphasis in this study was on Phase III, that is, on the evaluation of written responses by faculty members. Phases I and II were merely intended to serve the final phase. However, the first two phases provided some interesting data, about which brief mention will be made here. In-depth discussion of these portions of the study awaits a fuller analysis, which will be conducted at a future date.

First, one observation that was made about the study as a whole was the exceptional willingness of nurses to participate. Of approximately 130 nurses contacted over the three phases of the study, not one declined to take part. Although this might be perceived as indication that nurses are a particularly compliant group, such an interpretation is belied by the interest in and enthusiasm for the study exhibited by the nurses. Rather, it speaks to the perceived need

among nurses to address issues of nursing ethics; obviously, ethics is a topic of great concern.

This is particularly evident in acute care settings, where technological advances seem to have moved faster than our ability to make clearly "ethical" decisions (Zussman, 1992). The study, therefore, was shaped around ethical problems for nurses in acute care. It was reasoned that problems in this setting might be more "dramatic" and thus easier for nurses to identify as ethical concerns. Moreover, as the majority of nurses work in hospitals, it was felt that the acute care setting would be appropriate for a beginning exploration of nursing values.

Phase I

The nurses interviewed in Phase I of the study were, indeed, able to identify ethical concerns, and in many cases these were decidedly dramatic. What was remarkable about the interviews was the consistency of the problems identified. With few exceptions, they fell into the domains of what Jameton (1984) has termed moral uncertainty and moral distress. Seldom was there a clear-cut conflict between, for example, two competing moral principles; instead, the problems were highly textured and multi-faceted. Almost all dealt with situations in which the nurse felt a moral responsibility to protect the patient, or to give the

silent patient voice. What was being protected was the "personhood" of the patient. The nurse was in many cases uncertain as to what values were in conflict; she just knew that the situation didn't "feel" right to her. In other situations, nurses had clear ideas as to what should be done, but were unable to make their voices heard, or were constrained to act in a way that was in conflict with their beliefs. Clearly, the issues they raised were not the usual stuff of ethics textbooks, but rather were very personal, relational matters, in which the nurse's ethical problem seemed to stem largely from her connection with the patient and the obligation that relationship placed on her.

Cooper (1991), in a study designed to "begin explicating the moral framework informing the practice of nursing" (p. 23), had similar findings in her interviews with critical care nurses. In Cooper's study

> The striking finding ... was the manner in which the nurses relied on traditional moral principles, such as respect for persons, patient autonomy, beneficence, or fidelity, and at the same time relied on the moral response of care (p. 24).

To Cooper, the "moral response of care" was manifest in personal involvement and emotional investment in relationship with the patient. She pointed out that

"one could argue that the response of care was irrelevant to the outcome" (p. 27) in the situations described, which suggests that "care" was important, not so much in the actual decision-making, but in establishing a commitment to finding the best solution **from the patient's perspective.** Similarly, in the current study the nurse's distress seemed to arise when she perceived that the patient's best interests were not being served. Her judgement of the situation grew out of her connection with the patient, and her belief that she had an understanding of what the patient would want in the circumstances. Thus, her moral commitment lay in relationship, and in a kind of **knowing** of the patient which appeared to move beyond objectivity and reason. This way of knowing, which earlier I termed "empathic understanding", grew out of personal experience with the patient as person, and was rooted in a connectedness with the patient, which I have argued is characteristic of an ethic of care. The point will be expanded later in this discussion.

The inability to fulfil what was perceived as a moral commitment led to very strong negative feelings, in fact, to what could best be described as moral anguish. The depth of nurses' distress in this study could be gauged, not only by what they said, but by how they said it. While narrating their experiences, many

became obviously emotional, and tears were not uncommon. Nurses indicated that the process of sharing was cathartic for them, as they seldom found an audience for their concerns. In fact, some felt that they had been actively silenced when they tried to express their views, and this silencing had taken its toll. One way to effect the quieting of the nurse's voice was to dismiss nurses' concerns as being "just feelings", and as such, of little importance. For example, when one nurse tried to stand up for the patient in a situation in which care was being prolonged, the nurse in charge told the physician that "perhaps it was a method of coping that [the nurse] was using by standing up and saying what [she] thought was right for this particular patient". Clearly, there is a need to help nurses find a way to legitimate their concerns in the language of "ethics", rather than "just feelings". This is an area for future research.

Phase II

In Phase II of this study, another aspect of nursing ethics was explored -- the responses of student nurses and nurses in clinical practice to common clinical problems. Perhaps the most interesting thing about the findings was the diversity of viewpoints. In selecting participants, attempts had been made to obtain students from all levels of the undergraduate

program, and nurses from a wide variety of clinical areas. The objective was to get as broad a range of responses as possible. Evidently the objective was met.

One interesting question that arose from the data is the relationship between experience and the type of response to the questions posed. For example, were students more or less likely than graduate nurses to recognize ethical problems? Was experience related to beliefs about what the nurse should do in the situation? Previous research has suggested that as nurses become more experienced they "move more toward obedience and conformity" (Mayberry, 1986), but this research was based on DIT scores, which, as we have seen, may be faulty. Unfortunately for our interest in this question, participants in the current study were informed a priori that their demographic characteristics were for descriptive purposes only, and would not be linked to responses. The reason for this guarantee was to keep the answers as "pure" as possible; there was some concern that if individuals thought student responses would be compared against graduate nurse responses, they would be less candid. Consequently, demographic information was filed separately from written responses, and there is no way in this study to make those comparisons. The question

should certainly be explored further, as it would help to shed some light on the effects of experiential learning on ethical thinking. This again awaits further research.

As was mentioned above, one of the features of the interviews in Phase I was that many nurses expressed feelings of moral uncertainty; they were not really sure if their concerns were ethical problems or not, and they were often not clear on what the conflict was, although their discomfort told them there was a problem. Therefore, in developing the scenarios, an attempt was made to capture that uncertainty. The situations involving both Mrs. Jones and Mr. Smith were in what might be thought of as an ethical "grey area". The circumstances were open to interpretation, and might or might not be viewed as an ethical problem, depending on one's point of view.

The differences in perspective among nurses were reflected in their responses. As we have seen, for both scenarios nurses were not in agreement as to whether there was an ethical problem, what the dimensions of the problem might be, or what the nurse should do in the situation. This has significant implications.

First, it suggests that nurses do not have a common understanding of what constitutes ethics in the

professional context. Moreover, as much of the "ethics" of the situation was tied to definitions of professional responsibility, it implies that there is little consensus as to the parameters of the nurse's role. Findings of this study indicate that if nurses are to understand their ethical obligations, an agreed-upon definition of the nature of nursing practice must be established. In the absence of a distinct role definition for nurses, it is difficult to demarcate a nursing ethic (Penticuff, 1991). Yeo (1989) called for an integration of nursing theory with nursing ethics, for in his view, ethics is foundational for nursing practice. I suggest that the relationship between nursing theory and ethics is dialectical. Nursing theory leads to a clearer understanding of nursing role; consequently, as nursing theory is better explicated, a better understanding of nursing ethics will result. Conversely, nursing ethics will inform nursing theory, and lead to a more precise definition of the nature of nursing practice.

The reciprocal relationship between ethics and role definition is illustrated by a study of ethical decision-making among practising lawyers (Jack & Jack 1989). The researchers were able to identify four separate groups according to their level of adherence to traditional values, as defined within the profession

of law. These groups were further distinguished by their "care" or "justice" orientations, as follows,

> Strong role identification and little or no moral tension characterize Positions 1 and 2. Attorneys in these position have a relatively low degree of care reasoning and a high utilization of rights thinking. In Positions 3 and 4, strength of role identity diminishes and moral tension rises. The percentage of care responses correspondingly increases (p. 126).

Thus, a rights orientation was associated with traditional role definitions. The authors then proceeded to examine the four role identity positions in light of Kohlberg's theory. They noted that

> Attorneys in Position 1, of maximum role identification, speak with a conventional voice fully accepting the tenets of professional role. ... These attorneys speak frequently of the rules of the game ... Positions 2 and 3 are characterized by tension that results in subjugation of personal morality and perhaps in moral cost. These are transitional positions between conventional and postconventional thinking. A perspective outside of social convention questions the rules of the game ...Personal moral standards compete with

> institutional and professional values. ... In the minimum role identification of Position 4, postconventional attorneys stand beyond the social contract and make independent judgements about morally correct conduct. Rules ... no longer provide the final answer to what is morally right. (Jack & Jack, 1989, p. 128-129).

These findings have obvious significance for nursing. Lawyers' balancing of traditional values and humanistic considerations looks much like nurses' balancing of "professional/institutional obligations" and "patient as person", which lends strength to the framework developed in this study. However, as mentioned above, the exploration of such ideas in nursing is handicapped by the lack of a commonly held moral tradition or professional role definition. Unlike the legal profession, nursing has no clearly established "rules of the game", and categorizing individuals regarding their acceptance of professional values becomes more difficult.

Another implication of the observed lack of agreement among nurses in the current study has to do with peer support in the clinical setting. It is important to remember that it is "nurse as person" who is making ethical decisions. If nurses do not feel their ethical concerns are recognized by their

colleagues, they may experience considerable distress. In Phase I, one nurse indicated that the failure of her peers to acknowledge her concerns as legitimate had resulted in her leaving nursing for an extended period. In her words,

> I left under an incredible strain. I felt very alone ... I felt that my doubts were almost obscene ... if I brought it up people would just say, oh, you know, you're weird, or you're just too sensitive. When are you going to toughen up?

The importance of shared understandings was demonstrated by Zussman (1992) in his extensive study of medical ethics in intensive care (ICU). He showed how physicians developed a kind of professional solidarity within the ICU that led them to a common understanding of right action. Unfortunately, he noticed no such solidarity among nurses. Rather, his description was one of confusing and conflicting loyalties and obligations among nurses in the ICU. For example, one nurse described the nurse's role as including considerations of

> How the patient is doing, not only in a physical realm in terms of their bodily secretions and everything, but maybe in how they and their family are coping, how the patient is coping, what the patient desires (p. 70).

This nurse included patient advocacy as an important component of her role, suggestive of a moral orientation in the direction of "patient as person", that is, of a "care" focus. However she was, according to Zussman, far from typical. In his view, most nurses functioned more as technicians than as patient advocates. They seemed content to bow to the authority of the physician, accepting very different limits to their role. In other words, their emphasis was on "professional/institutional obligations", which I have suggested may reflect more principles-oriented reasoning.

Nurse's responses to the ethical problems presented in this study support Zussman's observations. In view of the lack of agreement about nursing obligations, it is not surprising that some of the nurses in this study felt that they got little support from their peers. There is unquestionably a need for increasing dialogue among practising nurses about the nature of ethical commitment.

Phase III

Measurement Issues

Perhaps the most significant finding in this study was the astonishing lack of agreement among faculty members as to the quality of responses to ethical problems. Even those individuals who seemed, on

reading the interviews, to be most similar conceptually (Faculty 2 and Faculty 7 on the Jones scenario) could only agree about half the time. Furthermore, those same individuals were in far less agreement on the Smith scenario. Similarly, other faculty pairs who were in high agreement on one scenario were not necessarily in harmony on the other. From the measurement perspective this has interesting ramifications.

First, it suggests that if, as I have argued, "nurse as person" is the defining factor in decision-making, it may be impossible to arrive at an acceptable measurement solution to the problem of evaluating quality of ethical reasoning. As we have seen, "nurse as person" is highly complex, and each individual interacts with each situation in a unique way. We have seen that the inter-rater reliability of the current approach to evaluating ethical thinking is highly questionable, at least with these scenarios. One might suggest that reliability would improve if the scenarios were more clearly drawn, or were less complex, but that itself presents difficulties. The scenarios used for this study were developed as representative of real-life problems; if the objective of ethics teaching is to improve the individual's ability to solve such problems, then simplifying the problem statement would

have impact on the validity of evaluation. The ability to solve simple, "decontextualized" problems probably has little relationship to the ability to solve complex problems in practice. We are, therefore, on the horns of a dilemma: if we improve reliability, we decrease validity.

Another issue surfaced in this study because two scenarios were used. In many cases respondents were rated differently on each of the two problems. This calls into question the validity of the idea of evaluating an individual's moral reasoning using scenarios and paper-and-pencil tests. There are profound complexities in any situation in which ethical problems reside, and, as has been seen, each individual interacts with the situation in a different way. One's personal orientation (that is, "nurse as person") determines which features of the situation are attended to and which are ignored, which actions are acceptable and which are not. It seems feasible that one would reason differently about different situations. Kohlberg (1981) suggests that it is possible to measure the "level" of an individual's ethical reasoning. Implicit in this view is the idea that the level remains consistent across situations. He does not make clear, however, how this notion of staged reasoning translates to the professional context. In the health

care setting, depending on such things as experience, a nurse might exhibit a more "mature" level of reasoning in one situation than in another, because the values linking "professional/institutional obligations" and "patient as person" vary subtly across situations. Thus it may not be possible to capture an individual's "level" of reasoning about professional ethical problems, as this may be a faulty concept.

The discussion to this point has, to a large extent, focused on the question of moral **reasoning**. Kohlberg's construction of the question is essentially silent on the **values** that underly an ethical decision. An individual's reasoning may appear very sound given certain values and assumptions, but these values may not be congruent with professional expectations, which begs the question about the salience of moral reasoning measures in the professional context. It may be a relatively easy matter to examine complexity of reasoning. Experience with the SOLO taxonomy suggests that, given appropriate training and guidelines, individuals could become quite adept at this method of evaluating written responses. However, the problem is that solutions to real-life ethical problems are not value-neutral, and it is difficult to separate considerations of structure from considerations of content. The "nurse as person" defines an acceptable

response, and this definition depends on individual values and subtle interactions. In this study, several faculty members indicated that they were essentially unconcerned about the conclusions to which the respondent came; instead, they wanted to see a logical and coherent argument. Yet those who focused on structure were not in high agreement with one another regarding quality of responses (for example, Faculty 1 and Faculty 6). In reading their transcripts it became evident that, although they had eschewed considerations of content, they wanted to see particular content elements in the responses. For example, Faculty 1 was prepared to place a response in a lower category in part because "the person talks about the conflict between medicine and nursing, and that nursing strives to save lives and preserve life, or to respect patient autonomy. And I don't personally believe that patient autonomy is restricted to nursing" (Faculty 1, p.9). It seems that what was being evaluated was much more than reasoning. It appeared to include underlying values and beliefs as well.

Thus, the problem with using this paper-and-pencil method to evaluate ethical thinking are twofold: 1. moral reasoning ability may not remain consistent across situations, so it may be impossible to get an accurate representation of how a person would perform

when faced with a clinical problem; and 2. values and beliefs appear to be highly individual, which suggests that reliability may unachievable. In response to the latter concern, perhaps attention should be directed to finding ways to increase agreement on questions of value. But this is probably more a philosophical than a measurement issue.

Bases for Ethical Decision Making

In this study, it was interesting to note that faculty did not refer to normative theories at all in describing why they rated responses as they did, and only two faculty mentioned professional codes of ethics. Three seemed to be using bioethical theory to some extent as a basis for their views; they indicated that they were looking for evidence that the respondent had considered issues of beneficence, non-maleficence, and autonomy. However, it was far from clear how they were defining these terms. It appeared that faculty were relying on no formalized method of structuring their thinking; instead, they gave consideration to a number of factors which were interwoven in a complex tapestry. The interpretive framework described earlier provided the background for a very personal picture, the details of which were individually drawn.

Not surprisingly, elements in the framework were similar to the themes identified in Phase I. This was

in part a result of the deliberate structuring of the scenarios to capture these themes. What was interesting, however, was the way in which the various elements interacted to shape decision making, and the centrality of "nurse as person" to the decision-making process. The situation itself seemed of less importance than the interaction of the individual with the situation. If that is indeed the case, then it is important to contemplate how particular considerations of "nurse as person" might impact on ethical thinking. I argue that some of these considerations include personal understandings of the professional role; the epistemologic position of the individual (loosely interpreted as "care" or "justice" orientation); the way in which the individual defines "patient good", and her willingness to commit to that good; and individual character. The argument is developed below.

As was noted, faculty (and respondents) seemed to be attempting to find a balance between professional role expectations ("professional/institutional obligations") and humanitarian considerations ("patient as person"). An essential difficulty arose however, because considerations of "patient as person" were entwined with professional obligations. Differences in beliefs about the degree to which involvement with the patient is a professional role expectation appeared to

be the fundamental issue. This seemed to have a strong influence on what features of the scenarios each person found salient, and to a large extent determined judgment about the appropriate course of action for the nurse.

The way in which professional role expectations and obligations were defined (and brought into balance) was influenced by personal characteristics of each faculty member (and respondent). Each individual brought different knowledge, attitudes and beliefs to bear on interpretation of the problem. For example, several faculty had experience with situations similar to those depicted in the scenarios. For some this experience seemed to result in application of what might be thought of as a "standard" solution, and a dismissal of the problem. In other cases, experience seemed to enrich the individual's understanding of the complexities of the situation.

In a study of ethical decision making in the clinical setting, Davis (1989) reported that philosophical inclinations were of major importance in determining how a nurse would react to a given ethical problem. The "epistemologic positions" (p. 67) of nurses influenced how they problem-solved. She noted,

> In general, nurses with an empiricist orientation adopted relatively uncomplicated and fixed

> perspectives. They placed high priority on what appeared to them as scientifically based principles such as objectivity, rationality, statistical evidence, safety, and certainty. Nurses with personalistic perspectives favoured a more patient-centred obligation ... Priority was given to the patient as the major factor in ethical decision making and the need for the staff to imagine the perspective of the patient (p. 67).

In the current study, as well, there were observable differences among faculty in the value they placed on objectivity and rationality. This was particularly evidenced by the differing views about whether intuition was a valid source of data in the Smith scenario. Although there was not enough information here to determine how those differences related to "epistemologic positions" in general, the findings would appear on the surface to support Davis's contention. Thus, individual beliefs about what and how we can know had an important bearing on what was considered "usable" data in the problem situations.

Davis (1989) mentioned "personalistic" orientations under the rubric of epistemologic considerations. In the context of an "ethic of care", one could also consider personalistic beliefs as having an ontological basis. Carse (1991) suggests that a

care orientation leads naturally, in discussions about ethics, "not only to the question "What is the moral status of this action (or policy for action)"? but also "What kind of person ought I to be?" To Gadow (1980, 1985) the answer is implicit in the notion of "existential advocacy", a way of being in relatedness with the patient, which in her view is the moral ideal of nursing. This seems similar to Noddings' (1984) conception of "ethical caring". Noddings notes,

> I am suggesting that our inclination toward and interest in morality derives from caring. In caring, we accept the natural impulse to act on behalf of the present other. We are engrossed in the other. We have received him and feel his pain or happiness ... (p. 83).

A way of **being** thus becomes a way of **knowing**, and the distinctions between epistemology and ontology become blurred. Gadow (1990) carries this possibility further. She examines the idea that there are many ways of "knowing", some of which are outside the cognitive realm (the traditional domain of epistemology). To know about the "other" in these alternate ways requires one "to be" in relatedness to that other. This suggests that the nurse can develop an understanding of the patient's wants and needs through the development of an empathic connectedness

with that patient. It further implies that, as ethical agent, the nurse is obligated to respond to those needs.

To the extent that the individual accepts these ideas of ethical "being", he or she will admit to such a way of knowing as legitimate. In this study, there were definite differences in the degree to which faculty (and respondents) accepted intuitive knowing as a source of data; these differences may be reflective, then, of both ontological and epistemological perspectives. This might be loosely translated into differences between "caring" and "justice" orientations.

In the interpretive framework the nurse's personal belief system was seen to affect the perception of balance between "professional obligations" and "patient as person". Balance was achieved when the (sometimes conflicting) aims of beneficence and preserving self had been negotiated for maximum positive effect. How the various elements were weighted, and how "positive effect" was defined, were again dependent on personal beliefs and values.

Before proceeding, it should be made clear how "beneficence" was being understood in this framework. In bioethics literature, beneficence is usually described as one of four principles (the others being

non-maleficence, respect for autonomy, and justice) which are to guide ethical decision-making (Beauchamp & Childress, 1989). The most common definition of beneficence is, in essence, the obligation to do or promote good (Davis and Aroskar, 1991). Beneficence is, however, often closely linked to paternalism, and is frequently represented as being in opposition to, or in conflict with, the principle of autonomy.

Pellegrino and Thomasma (1988) have constructed a model for medicine in which they see beneficence, not as one of several moral principles, but as an overarching goal defined as "acting in the patient's best interests". The way in which their view differs from usual delineations of the concept is that they propose that

> beneficence should be the fundamental principle guiding medical care ... [it] join[s] concern for the best interests of patients with concern for their autonomy. As a result the principle takes on the character of a shorthand that conflates two very important ethical concerns (p.54).

This view of beneficence seems to capture the essence of what nurses saw as important in the current study. As they reflected on the pros and cons of various actions, it was evident that they were, for the most part, concerned with the patient's best interests.

Autonomy was a central issue, but it was not seen as a supervening principle. Although for some the definition of "good" was clearly paternalistic, in most cases there was a sense that good would be defined in the patient's terms. Thus, beneficence became **the** moral commitment -- and perhaps the ultimate goal of care.

Pellegrino and Thomasma, in describing their beneficence model, make the point that the **character** of the individual making decisions is of enormous importance. It is that which determines the extent of commitment to beneficence, that is, the "extent to which the physician can be trusted to keep the good of the patient as her primary aim" (p. 34). Results of this study suggest no reason why the same should not be said of nurses. In fact, as we have seen, it is the individual characteristics of the "nurse as person" that determine how the problem is framed and how a resolution is conceived. "Nurse as person" also determines the degree to which the individual is willing to commit to beneficence, and the degree to which "protecting self" is important in the situation.

It should be pointed out here that protecting self does not necessarily stand in opposition to beneficence. Whether it does or not is, again, dependent on personal beliefs. Elsewhere (Davies &

Oberle, 1990; Oberle & Davies, 1992; Oberle & Davies, 1993) I have argued that in order to provide excellent care, the nurse must have a sense of wholeness. Maintenance of personal integrity thus becomes not only a need, but a moral obligation. Carse, in an exploration of the impact of "care" on biomedical ethics, offers support for this view. She maintains that

> a full account of the virtues of caretaking would need to spell out conceptions of proper self-regard - or care for oneself - as protection against self-effacement or problematic self-denial and as precondition of sound caring for others (Carse, 1991, p. 24).

This suggests that a nurse who holds an ethic of care might find that his or her personal integrity is strengthened by adopting a position of "existential advocacy" for the patient. On this view, protecting self would entail acting in the patient's best interest. This nurse might therefore weight the "patient as person" considerations more heavily in making decisions.

On the other hand, the situation might be such that acting in the patient's best interests would be perceived to engender some sort of harm for the nurse. If, for example, the nurse expected to be seriously

reprimanded for not following doctor's orders, she/he might feel that patient's wishes were of lesser importance. Professional/institutional obligations might be viewed as paramount. In this study, respondents were obviously divided on the Jones scenario; some felt they had to no choice but to comply with doctor's orders, while others felt that the patient's wishes should be upheld, no matter what the personal repercussions. This difference could have been a result of different perceptions of consequences to not following orders, or it could have been related to different levels of commitment to beneficence, that is, to a "caring" ethic.

I have argued that within "nurse as person" there is a relationship between character, beneficence, personal integrity and caring. The linkage of these concepts begins to sound very much like what has been called "virtue" ethics. Because the idea of virtue as a basis for moral decisions has been greatly distorted from its original Aristotelian conception (Taylor, 1991), it may be preferable to use the term "character" rather than virtue. Such philosophical ponderings aside, the foundation of this ethical perspective is that the most important moral question is not, "what ought we to do?", but rather, "what ought we to be?" Kupperman (1988) suggests that normative ethical

theories, with their emphasis on rationally derived rules of action, fail to take into account the character of the individual making moral decisions. By "character", Kupperman means "a complex that includes the presence or absence of dispositions to recognize certain situations as ethically problematic ... and dispositions to treat certain factors as having special weight in ethical decision" (p. 116). In his view, "the important ingredients of character are concerns and commitments" (p. 123). This is strongly reminiscent of the views expressed earlier in relation to the ethic of caring (Carse, 1991; Gadow, 1985; 1990). Virtue ethics has intuitive appeal; it "feels right" to think that one must have a certain quality of character and a certain belief in "right" conduct to be able to make sound value judgments. Kupperman (1988) maintains, however, that character in and of itself is not sufficient to inform moral decisions. Character ensures a predisposition to recognize ethical problems and to commit to their resolution, but "we need theory to be in a good position to criticize existing practices ... and effectively to structure reflection" (p. 123). In other words, both character and theory are required for excellence in decision making.

What, then, can we say about ethical theory for nursing? As we have seen, traditional normative

theories are founded on the belief that resolving an ethical problem is a matter of acting according to established rules, which can be derived through reason. Bioethical theory suggests that one must act according to principles which can be hierarchically ordered. Thus, in a given situation one simply determines which principles obtain, decides which is paramount, then acts accordingly. These theories are compelling because it seems that there **should** be some rules of right conduct, of the kind we were taught as children. Moreover, it seems sensible, as Kupperman (1988) has suggested, that traditional moral rules would be required to alert us to the presence of ethical problems. However, I have argued that rule-oriented approaches are incomplete, as they fail to take into account the interaction of the decision-maker with the situation. In addition, they give little attention to what counts as legitimate information to inform decision-making, and how that information can best be obtained.

The concept of an "ethic of care" has challenged traditional approaches, and made us pay attention to the possibility that solutions to ethical problems may be arrived at through ways other than rules and reason. It suggests that there may be ways of knowing that transcend cognition. However, care ethics is

essentially silent on the question of how to resolve situations in which conflicting values exist. This leads one to the conclusion that neither reason nor care alone can be depended upon to solve problems of the type frequently experienced in clinical practice.

Integrating Concepts

How can these disparate viewpoints be brought together in a meaningful way, such that they will help the practitioner make "best" decisions? Can we make sense of the centrality of "nurse as person" within the context of moral theory? Brody (1988) has offered an approach that seems to have considerable merit. He calls his contribution "the model of conflicting appeals". Although his theory deals with ethical decision-making in medicine, its elements might sustain the infrastructure for a parallel model for nursing ethics.

The presupposition upon which Brody's model is based is that "we have a fundamental cognitive capacity which enables us to recognize the moral value of individuals, actions, and social arrangement" (p. 12). Thus, his is an intuitionist account of moral reasoning. He maintains that moral decision making involves an initial assessment, followed by a tentative moral judgment. The judgment is then used in the formation of a theory "concerning which actions are

right or wrong, agents blameworthy or innocent, and institutions just or unjust" (p. 13). This theory becomes the basis for subsequent moral judgments about similar actions or situations. Like any theory, it must be tested and revised as necessary. Thus, it is not static, but dynamic and responsive to changing data and context. In forming moral judgments we must take into account a variety of considerations or conflicting moral appeals. The moral theory delineates which of the appeals has the greater significance in any given situation. We take this into consideration, then we use our judgment to decide what we ought to do.

The various considerations in making moral judgments in the physician-patient relationship include an appeal to 1. the consequences of our actions; 2. rights; 3. respect for persons; 4. virtues, and 5. cost-effectiveness and justice. For each of these appeals Brody outlines specific aspects that might be considered salient. For example, he suggests that when weighing consequences one must consider first, how likely the consequence will occur, second, how important the consequence is to the individual, and third, the extent of the impact of the action.

Brody describes two kinds of rights to be evaluated: procedural and substantive. The former involves such things as the right to participate in

decision making; the latter includes, among other things, the right not to have pain inflicted on oneself, and the right to be aided in health-threatening situations. Respect for persons means acting in a way that will help people "maintain their lives, their bodily integrity, and their capacity to choose and act" (p. 87). Each of these must be evaluated in light of other appeals in the particular situation.

The issue of virtues is interesting. Here Brody describes four virtues of importance in the health care setting, as follows:

> integrity (standing firmly by one's values and choosing in accordance with them), compassion (caring attempts to alleviate the losses of others), courage (acting on appropriate decisions without being excessively motivated by various fears), and honesty (not intentionally misleading people by providing false information and/or withholding other information) (p. 89).

Thus, in Brody's view, virtue is defined in terms of specific character traits, rather than as a general predisposition to "do good".

The final consideration, cost-effectiveness and justice, deals essentially with matters of distributive justice. As such it has less application for nursing

than for medicine, as nurses have little control over the distribution of scarce resources. This is evidenced by the fact that little attention was paid by respondents in the current study to justice issues. Nevertheless, it occasionally falls within the purview of nursing, and must be included in any complete theory of nursing ethics. It will not, however, be discussed further here.

The elements in Brody's model look remarkably similar to those in the interpretive framework used by faculty and respondents in this study. Unlike other moral theories, which generally depend on a relatively static ordering of rules and principles, Brody has taken into account the enormous complexity of real-life decision making, demonstrating that making decisions is a dynamic process that works almost like a dialectic; information comes in, is evaluated, a decision made, leading to more information, a reevaluation of the decision, and so on. This seems to capture the nature of thinking by participants in this study.

Thus, Brody has cast a unique mould for a decision-making process in medicine. The model does present several difficulties as a framework for nursing, however. First, in describing his model, Brody first sets out a number of conditions that detail the nature of the doctor-patient relationship. These

conditions are integral to decision making, as they impact heavily on how the various considerations will be weighted. Conditions of the nurse-patient relationship are very different from those between patient and physician, particularly because the nurse works within a hierarchical system in which the physician has primary authority. Therefore, the conditions would have to be redrawn.

Another concern is the place of virtues in the model. Although on the surface Brody seems to be following the recommendation of Kupperman (1988), who suggests that both character and theory are important to decision making, a closer examination reveals that Brody's idea of virtue is particular character traits that help an individual act on a decision. He is more or less silent on the issue of virtue as a general sensitivity to the presence of ethical problem. Nor does he tackle the approach to virtue that seems inherent in the caring literature, that is, that virtue defines a willingness to enter into an engaged relationship with the patient, and a preparedness to be receptive to the other.

Thus, Brody fails to attack the problem of "what counts as legitimate data?" He notes that his is an epistemological model about how we come to know about what is right and wrong (p. 79), but he only defines

the process, not the source of information that feeds into the process. In relying on our "fundamental cognitive capacity" to develop theories about "ought", he denies (or simply ignores) the possibility of other ways of knowing, implied by a model of caring ethics.

If thought is to be given to developing Brody's (1988) model into a model for nursing ethics, these deficiencies will have to be addressed. Some help for this endeavour can be found in literature in developmental psychology. Hague (1990) has suggested that Dabrowski's (1964) theory of Positive Disintegration might serve to bridge the gap between normative principles-oriented ethics and evolving concepts about an ethic of care. According to Hague (1990), if we are to escape from ethical relativism, we must achieve a kind of moral objectivity. In his view, moral objectivity can be gained through "authentic subjectivity", which he describes as a developmental process, supported by "cognition, affect, imagination, reflection, the wisdom of experience and sensitivity in a context of care and responsibility". What one is striving toward is what Dabrowski (1964) has described as a "personality ideal". In growing toward this "ideal", one assesses, evaluates, dismantles and rebuilds "theories" about "right" behaviour, much as Brody (1988) has suggested. The process is at some

point intuitive, but at the same time depends on rational thought. Thus, ethical objectivity "is not found in mere subjective feeling, nor in purely cognitive functioning nor in blind conformity to the majority". Instead, "it is the changing relationship between the investigator and what he or she observes (p. 124). What this suggests is that the "care versus justice" (read "principled reasoning") dichotomy fails to represent accurately the nature of ethical thinking, and the dialectic between rationality and interpersonal relatedness. Caring as a way of knowing may add necessary fuel to the fire of rational thought. If this is so, then the questions become, "How does this relationship grow? How does a health care professional, or, as is our central concern, the "nurse as person", develop "moral objectivity"?

Dreyfus and Dreyfus' (1990) "phenomenological account of the development of ethical expertise" (p.237) may provide further insights. In a previously articulated model Dreyfus & Dreyfus (1986) suggested that skill acquisition proceeds in five stages: novice, advanced beginner, competence, proficiency, and expertise. In their more recent work (Dreyfus & Dreyfus, 1990) they have carried this model into the realm of moral development. The process of gaining expertise in ethical decision making is, they maintain,

much the same as the process of acquiring skill in any task. In their view, "beginners make judgments using strict rules and features, but ... with talent and a great deal of involved experience the beginner develops into an expert who sees intuitively what to do without applying rules and making judgments at all" (p. 243).

What, then, constitutes expertise in ethics? According to Dreyfus and Dreyfus, it is "doing what those who already are accepted as ethical experts do and approve" (p. 245). Thus, theirs is essentially a normative account that implies that there are accepted standards of "right action". This view is not incompatible with the notion of professional ethics. Within a profession there are, as we have seen, codes of ethical conduct developed in the expectation that they will guide behaviour in practise. Nor is it necessarily incompatible with an intuitionist model such as Brody's (1988). Brody does not, explicitly at least, reject the notion that intuitionist accounts could coalesce into a normative standard. He does say that we have a "cognitive capacity" to know what is right. What Dreyfus and Dreyfus' model could do, then, is extend Brody's account to explain the growth of intuition, which would entail moving beyond cognition and practical reasoning.

The idea of applying the Dreyfus model in nursing

is not new. In her highly convincing From Novice to Expert: Excellence and Power in Clinical Nursing Practice, Patricia Benner (1984) has described the progressive development of nursing expertise through the five stages outlined by Dreyfus (1979). More recently, she has turned her attention to what she calls "ethical comportment" (Benner, 1991), claiming that skill in nursing practice requires skill in ethical thinking (and behaviour), which grows through experience. Ethical comportment, "the embodied, skilled know-how of relating to others in ways that are respectful and support their concerns ... refers to more than just words, intents, beliefs, or values; it encompasses ... thoughts and feelings fused with physical presence and action" (p. 2). This sounds very much like the "ethic of care" described earlier. What is new here is that Benner's concept of developing expertise in "ethical comportment" offers some suggestion as to how such skill might be taught and learned.

Implications for Teaching and Evaluation

I have argued to this point that current models of nursing ethics are inadequate to capture the dynamic between rules, reasoning and intuitive knowing. Further, I have implied that a new approach to ethical theory for nursing must incorporate elements of

principled reasoning, character or virtue, and the ethic of care, with beneficence as the stated goal. Bringing together the various perspectives described above, it seems that what we want to do is work toward moral objectivity and a personality ideal within the "nurse as person". That ideal, in the professional context, looks like "expertise". Expertise involves excellence in "ethical comportment", which means success in weighing and ordering values such that "best" decisions are made. Knowing what is "best" depends, not just on accepted norms, but on authentic reflection about any given situation. And authenticity demands relatedness and receptivity to the other.

Although these relationships must be explicated in much greater detail than is possible here, it seems evident even at this early stage, that in teaching nursing ethics we must go far beyond traditional moral theories. If we accept Benner's notion of "ethical comportment" as the ideal for nursing, then directions for teaching become quite clear. On this premise, we would have to say that the goal of ethics teaching must be on the "nurse as person", that is, on the development of character, such that the individual is sensitive to the presence of moral problems, and committed to their resolution. Attention must be paid to development of reasoning skills, but as well, there

must be attempts to encourage a willingness toward relatedness and receptivity.

How can this be accomplished? First, there is room for didactic approaches. Critical reasoning skills can be fostered through exercises in which logical development of arguments is required. Relevant ethical theories can be explored, discussed and critiqued, but this must be done in the context of clinical problem solving. That is, the utility and limitations of such theories in practice must be examined. However, as Dreyfus and Dreyfus (1990) have noted, "principles and theories serve only for early stages of learning; no principle or theory 'grounds' an expert ethical response" (p. 252). Moreover, ethical decisions in the practice setting (as elsewhere) are rooted in beliefs and values. In a setting in which there may be many conflicting ethical appeals (cf. Brody, 1988), the individual must develop a way of determining which appeals have dominance in any given situation. This is not simply a matter of recognizing and rank ordering values; instead, it is a holistic process which Hague (in press) calls "heterarchical". According to Hague, heterarchy is "a systemic relationship reflective of relative behaviour choices which are dependent on time and context" (p. 11).

Decisions about "right behaviour" then, depend on

an understanding, an awareness of the context and its ethical dimensions. To develop this awareness, we must first, as Andre (1992) suggests, "learn to see". She remarks that "noticing another's subjectivity is a skill that can be learned" (p. 150). On the surface, it seems reasonable that in attempting to learn such a skill, one might turn to descriptions of ethical decision making by experts. Dreyfus and Dreyfus (1990), however, indicate that the expert practitioner may be unable to articulate the elements that went into an ethical decision, as there may be little conscious reasoning involved. Instead, the resolution to the problem may be "apprehended", rather than arrived at through an explicable cognitive process. If this is the case, how then can we benefit from the expert's abilities?

Possibly the most effective approach would be to team novice practitioners with experts, and to build in time for reflection on the nature and resolution of problems experienced in practice. However, practical problems (largely related to finances) likely move this solution into the realm of the idealistic. Another, more practical approach has been suggested by Benner (1991). She points out that one way to communicate skills in ethical comportment is through analysis of narratives about excellent practice. Such "moral

discourse" can help the beginning practitioner to become sensitive to qualitative distinctions in specific situations.

Of course, sensitivity to ethical problems, and understanding of desirable solutions are not sufficient. We must also aim to build into our students the kind of character that increases the likelihood that moral thinking will lead to moral action. The nurse as moral agent experiences many constraints on his or her behaviour. As we have seen, institutional and professional obligations may be at odds with the patient's best interests. Explorations of personal values, of professional role expectations, and of considerations of such things as patient rights may help to foster an awareness and a moral commitment in students. The interpretive framework identified in this study should prove useful for structuring discussion.

This all leaves the question of how to evaluate the effectiveness of ethics teaching essentially unanswered. It seems clear that, given the contextual nature of ethical problems, paper-and-pencil approaches are inadequate. Although they may be useful for examining retention of didactic material, such as the content of particular ethical theories, they will shed little light on how an individual actually pieces

together and uses information in decision making. It seems that somehow we must make greater use of narrative, but evaluation cannot rest on static, written responses. One problem with written responses is a real danger that what is being evaluated is writing skills, not ethical thinking (or acting). Another problem is that a single written response says little about process of an individual's thinking. For example, if in a written response, an individual fails to mention a salient feature, does one assume that the individual lacked sensitivity, or that the feature was considered, but not deemed worth mentioning because it had been dealt with adequately?

If we really wish to capture elements of process, what we should probably use is an interactive process involving student and teacher. Hypothetical scenarios could be enacted on videotape, and students asked to respond verbally. This would permit the teacher to probe as necessary. Of course, this approach is not without problems, not the least of which is a question of reliability. Particularly in light of the fact that professional ethical standards and the parameters of the nurse's role have been poorly articulated to date, it may be difficult to get two individuals to agree on whether the student had responded appropriately.

This leads to the conclusion that valid and

reliable evaluation of the quality of ethical thinking is an unattainable goal at this time. However, that may not be a matter for great concern. It may be that what we should be focusing on is not summative, but formative evaluation. The process of evaluation in itself may be an important step toward increasing awareness, sensitivity, and concern for action. At present, that may be the best we can hope for. The rest is a matter for further research.

Research Implications

From this study, it should first be evident that there is an urgent need, as I have pointed out, to increase the exchange between nursing ethicists and nursing theorists. Until the parameters of the nursing role are better delineated, questions about the nature of an appropriate ethic for nursing, and whether such an ethic is distinct from that of other professions, must remain unanswered. However, ongoing explorations in nursing ethics can, as we have seen, contribute to our understanding of the nature of nursing and the expectations inherent in that role. Many of the questions raised by the results of this study lend themselves to further research. I will, therefore, advance a tentative outline of a research program designed to address some of these issues.

As Fry (1987) indicates, there has been little

research to explore the relationship between formal ethics teaching and ethical thinking. From this study, it is apparent that the major difficulty is that there appear to be no adequate measures to capture changes in or levels of ethical problem-solving. Many nursing authors have rejected the work of Kohlberg as being inappropriate for nursing, because Kohlberg focuses on principled reasoning. However, our data suggest that there is an element of principled reasoning in nursing thinking about ethical problems. Moreover, Jack and Jack (1989) have suggested that Kohlberg's stage levels might be related to a care orientation. As was described above, they related a care orientation to post-conventional stage reasoning. Therefore, it may be unwise to reject Kohlberg's and/or Rest's well-validated instruments for measuring moral reasoning without further exploring possible relationships between stage theory and caring ethics.

One way this might be approached is to adapt the method used by Jack and Jack (1989), but extend it to look more systematically at how care orientation and stage levels are related. From the current study it is apparent that the scenarios depicting common problems can be used to elicit a range of responses from nurses. A proposed study method, then, would be to give the scenarios to practising nurses, and capture their

responses on audio tape in interview format. This would obviate the problem of static written responses. For their study, Jack and Jack (1989) produced a well-documented coding scheme for analyzing interview data. Using this coding format, they were able to attain high levels of inter-rater reliability in assigning responses to categories of care and justice orientation. Their method could be used, with very minor adaptations, for coding interview data with nurses.

As part of this same study, nurses' level of stage reasoning would be assessed using Rest's DIT, which is quickly administered, and has been shown to be highly reliable. The relationship between DIT scores and code categories could then be examined. This could help to enrich our understanding of the generalizability of stage theory to context-specific problems in professional ethics. It might also help us to determine if strengthening an individual's reasoning skills would help their clinical problem-solving abilities.

Another approach might be to attempt to include the concepts of Benner (1991) and Dreyfus and Dreyfus (1990) in the analysis. It should be possible to have nursing supervisors rate interviewees according to their level of expertise (from "novice" to "expert")

according to some pre-established criteria. It might also be advisable to have nurses rate themselves. One could then examine relationships between proficiency level, care/justice orientation, and stage reasoning. Of course, there are numerous methodological difficulties here, but it might be possible to overcome these to an extent sufficient for an exploratory study.

The same kind of approach to relating expertise, stage reasoning, and care/justice orientation might be used with other professionals, as well as nurses. In examining similarities and differences across professions, the parameters of ethical thinking and decision making in each profession might be better delineated.

Turning more directly to the problem of evaluating the effectiveness of ethics teaching, and building on experience gained in this study, a somewhat different strategy might be employed, adapting the work of Bebeau and Rest (1986). These authors developed the Dental Ethical Sensitivity Test (DEST) for examining ethical reasoning in dentistry students. Their method involves use of audio tapes describing moral dilemmas in dental practice. The respondent is required to listen to the tapes, then at some point assume the role of dentist in the situation, and act out the appropriate response on tape. Responses are content-analyzed and scored

according to a set of descriptive criteria. This approach might be adapted for use with nursing students, using typical ethical problems such as the ones developed for the current study.

The difficulty of course would lie in the development of scoring criteria, which is still likely to present problems, for the many reasons uncovered in the current study. Perhaps the notion of specific scoring criteria will have to be abandoned altogether, in favour of more general descriptions of patterns of acceptable behaviour. For this task research should be directed toward uncovering values and valuing in the nursing context. As a beginning, a stage approach is proposed. This would involve careful analysis of the written responses obtained in this study, with the objective of extracting statements of value, such as, "I believe that life should be preserved at all cost", and "I believe that nurses should follow institutional policy at all times". Nurses would then be asked to sort or rank order the values according to their personal beliefs. The next step would be to present them with the two scenarios used in this study and record their response on tape. The scenario would then be adjusted to change its focus somewhat. For example, the age of Mrs. Jones could be decreased, or the family of Mrs. Jones could be seen to disagree with her

decision not to have heroic measures performed. The nurse would be asked to respond again, and her response would be tape-recorded. Analysis of the tapes would be aimed at uncovering fine features of the decision-making process, looking at the relationship between individual values and critical features of the situation. Eventually this should lead to better understanding of what nurses value, how they make decisions, and what they consider to be acceptable behaviours within the broad philosophical tenets of nurse "as person" and as caring professional. This knowledge could then be used in establishing acceptable portrayals of "ethical comportment", to use Benner's (1991) term.

Lastly, data from this study suggest that there is a great need to assist nurses in practice with articulating their concerns, that is, in "finding voice". This will involve a process of social change. One tool for effecting such change is what has been called "action research", in which "persons conducting the research act as citizens attempting to influence the political process through collecting information. The goal is to promote social change that is consistent with the advocates' beliefs (Bogdan & Biklen, 1992, p. 201)." Under this rubric one could involve nurses from various groups in discussion and problem-solving

sessions, in which a variety of strategies for making their voices heard could be explored. In this way the systematic methods of science can be used to respond to what is, in effect, a moral appeal to which the researcher, as moral agent, must attend.

In conclusion, the suggestions for research outlined here are but some of the many avenues that should be explored in the important field of nursing ethics. Situations such as those described in the opening paragraphs of this document are a very real source of pain to nurses and other caregivers, who must, on a daily basis, balance many conflicting moral appeals. Finding a way to help them do this seems to be an extremely challenging but worthwhile endeavour.

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APPENDIX A

EXPLANATION OF THE STUDY

Name of Researcher: Kathleen Oberle RN MN
PhD Candidate
Department of
Educational Psychology

Address of Researcher: 3-104 Education North
University of Alberta

Telephone: Business: 492-3762
Residence: 987-2869

Project Title: Evaluating Nursing Ethics

I am a doctoral student in the Department of Educational Psychology at the University of Alberta. As a registered nurse, I am interested in the question of nursing ethics and the effectiveness of ethics teaching. My long term research interest is in finding ways to describe the quality of ethical decision-making among nurses.

In this study, I hope to develop a way of evaluating the development of moral reasoning in student nurses. As well, the tool developed through this research could be used to investigate questions about ethical thinking of nurses in their professional practice. The present study will take place in two phases.

In the first phase, about thirty nurses working in an acute care hospital will be interviewed. They will be asked to describe ethical problems they have experienced in the course of their work. The interviews will be analyzed in detail, and common themes identified. These themes will be used to create about three hypothetical ethical problems that are typical of the problems facing nurses in an acute care setting. After the problems have been developed Clinical Nurse Specialists will examine them for clarity and representativeness.

In phase two of the study, twenty practising nurses and twenty student nurses will be asked to read the problem statements and write what they think the nurse should do in the situation, and why. Answers will then be given to twelve members of nursing faculty in a number of schools and universities. Faculty members will be asked to sort the answers into piles, representing poor to excellent responses. After the sort is completed, each faculty member will be interviewed to determine why each answer was rated as

it was. The idea is to determine what, in terms of both structure and content, each faculty member expects for each level of answer. From these interviews, a general description of the expected answer in each category (from poor to excellent) will be developed. Faculty members will review the descriptions, and revisions made until there is agreement.

The descriptions thus developed can be used as a basis for comparison of student responses to the ethical dilemmas. It is hoped that this will provide a first step toward evaluating the effectiveness of ethics teaching. It may also provide a basis for examining reasoning among practising nurses with varying amounts of experience.

APPENDIX B
CONSENT FORMS

INFORMED CONSENT

Nurse Participant: Phase One

Title of Research - Evaluating Nursing Ethics

Researcher
Kathleen Oberle
PhD Candidate
Educational Psychology
University of Alberta
phone: Bus. 492-3762
Res. 987-2869

Advisor
Dr. Tom Maguire
Professor
Educational Psychology
University of Alberta
phone: 492-3762

Purpose of the Study

The purpose of this study is to develop a way of evaluating how student nurses think about ethical problems. The results of this research could also be used to study how graduate nurses think about ethics. In this phase of the study, I will develop descriptions of typical ethical problems faced by nurses in practice.

Procedure

I will interview you at a time and place on which we both agree. The interview should take about 30 to 45 minutes. I will ask you about your age, nursing experience, and background education. You will then be asked to tell me about an ethical problem you have had in practice. The interview will be tape-recorded. I will later type all the interviews from the recordings. The typed interviews will be used to make descriptions of common ethical problems in nursing.

Risks

Taking part in the study may not help you directly. However, information from this study may help instructors to teach students how to deal with ethical problems. It may also be useful in future research on nursing ethics.

Although unlikely, it is possible that talking about your experience might cause you some distress.

If the distress is more than you can deal with you may contact Occupational Health Services (phone 492-6968). They will refer you to a suitable counsellor.

Voluntary Participation and Confidentiality

Your name has been given to me by your supervisor as a nurse who might be able to help with this study. Your name is one of a number I have received. Your decision to take part in this research is completely voluntary. I will not tell your supervisor whether or not you are part of the study. Your name will not be connected with your interview or with the ethical problems developed. You will only be identified by a number. Only the researcher will know your number. All information will be kept in a locked cabinet. Tapes will be erased at the end of the study. Typed copies of the interviews will be kept for 5 years and then destroyed.

The typed interviews will be used to develop descriptions of typical ethical problems. They may also be used in general discussions about nursing ethics. Portions of interviews may be used in written reports about the research, but your identity will be kept secret. Every attempt will be made to make sure that you cannot be identified from written statements.

If after the interview you change your mind about being involved in the study, you may call the researcher. Your tape and the typed copy will then be removed from the study.

If you have any questions or concerns about the research you may call the researcher, Kathy Oberle, or advisor, Dr. Tom Maguire.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

INFORMED CONSENT

Student or Nurse Participant: Phase Two

Title of Research - Evaluating Nursing Ethics

Researcher	Advisor
Kathleen Oberle	Dr. Tom Maguire
PhD Candidate	Professor
Educational Psychology	Educational Psychology
University of Alberta	University of Alberta
phone: Bus. 492-3762	phone: 492-3762
Res. 987-2869	

Purpose of the Study

The purpose of this study is to develop a way of evaluating how student nurses think about ethical problems. The results of this research could also be used to study how graduate nurses think about ethics.

Procedure

I will meet with you at a time and place on which we both agree. You will be given some materials to fill out. The form will ask for information about your age, education, and nursing experience (if applicable). You will then read some descriptions of nursing ethical problems. For each problem you will write what you think the nurses should do, and why. This should take you about an hour. You will mail your answer back to me in a self-addressed envelope.

Faculty members from university and hospital schools of nursing will be given everyones' answers. Faculty will be asked to sort the responses into categories according to how good they are. Faculty will then be interviewed. They will be asked why they sorted the responses as they did. The results of these interviews will be used to create descriptions of "poor, fair, good, better, and best" answers. These descriptions can then be used to evaluate the responses of nurses or students to the ethical dilemmas.

Risks

Taking part in the study may not help you directly. However, information from this study may help instructors to teach students how to deal with ethical problems. It may also be useful in future research on nursing ethics.

Voluntary Participation and Confidentiality

Your participation in this study will be kept confidential. You will be asked not to sign your name to your written answers. All information will kept in a locked cabinet. Written answers will be kept for 5 years and will then be destroyed.

Your answers will be typed by the researcher to prevent anyone from recognizing your handwriting. Your typed answers will be seen only by the researcher and the faculty. Portions of the responses may be used in written reports about the research, but your identity will be kept secret.

If you have any questions or concerns about the research you may call the researcher, Kathy Oberle, or advisor, Dr. Tom Maguire.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

INFORMED CONSENT

Faculty Participant: Phase Two

Title of Research - Evaluating Nursing Ethics

Researcher
Kathleen Oberle
PhD Candidate
Educational Psychology

University of Alberta
phone: Bus. 492-3762
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Advisor
Dr. Tom Maguire
Professor
Educational Psychology

University of Alberta
phone: 492-3762

Purpose of the Study

The purpose of this study is to develop a way of evaluating moral reasoning in student nurses. As well, the results of this research could be used to examine questions about ethical thinking of nurses in general.

Procedure

You will be asked some questions about your education, teaching experience, and experience teaching ethics. You will then be asked to read the responses of about 20 nurses and 20 nursing students to two ethical problems. You will sort the responses into piles according to their quality. It is expected that this task will take about five hours. At a later time you will be interviewed to determine why you sorted the responses as you did. The interview should take about an hour. The interviews will be tape-recorded and typed. The results of these interviews will be used to create descriptions of "poor, fair, good, better, and best" answers. Once the descriptions have been developed, you will be asked to review and edit them. An attempt will be made to create descriptions with which all faculty members can agree.

Risks

Taking part in the study may not help you directly. However, information from this study may help instructors to teach students how to deal with ethical problems. It may also be useful in future research regarding nursing ethics.

Voluntary Participation and Confidentiality

Your name has been suggested by your Dean/Director as someone who might want to help with this study. Your name is one of a number I have received. Your participation in this research is voluntary, and will be kept confidential. Your name will not be associated with your interview or with the descriptive statements created.

All tapes and typed copies will be kept in a locked cabinet. Tapes will be erased at the end of the study. The typed copies will be kept for 5 years and will then be destroyed.

Your interview will be used to generate descriptive statements about different levels of student responses. Portions of the interviews may be used in written reports about the research, but your identity will be kept secret. Every attempt will be made to ensure that you cannot be identified from written statements.

If after the interview you change your mind about being involved in the study, you may call the researcher and your tape and the typed copy will be removed from the study.

If you have any questions or concerns about the research you may call the researcher, Kathy Oberle, or advisor, Dr. Tom Maguire.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

APPENDIX C
INSTRUCTION SHEET

April 6, 1992

Dear

Thank you for agreeing to help me with my study. Enclosed you will find three things: a consent form, a form for background information, and two scenarios. The consent form has been included to ensure that you have been fully informed about the study, especially the confidentiality issues and the measures taken to protect your anonymity. The background information is to allow me to have a profile of the participants in the study.

Please read and sign the consent form and fill in the background information. Then read the two scenarios and answer the questions at the end of each one. Your answers can be as long or as short as you wish. To protect your anonymity I will open all the envelopes and remove the consent forms before I read any of the responses. The consent form is on coloured paper to make this task easier. I will type all responses so there is no danger that anyone will recognize your handwriting. Feel free to answer the questions any way you want. After the envelopes have been opened and the consent removed there will be no way to connect individuals with their responses.

Once you have answered the questions, please <u>put them and the consent form in the stamped envelope and drop the envelope in the mail</u>. I would greatly appreciate having the answers back as soon as possible.

Again, thank you for helping. I hope that this study will prove useful to those teaching ethics and professional values in nursing programs. This kind of research can only be done with the participation of people such as yourself. I believe that as a participant, you will be contributing to the improvement of nursing education, and ultimately to nursing practice.

If you have any questions about the study or about what you are supposed to do, please give me a call. I can be reached at home (987-2869) or at my office at the University (492-3762).

Sincerely,

Kathy Oberle, R.N., M.N.
Ph.D. Candidate
Educational Psychology

APPENDIX D
DEMOGRAPHIC QUESTIONS

BACKGROUND INFORMATION
(Students)

1. What is your age?

2. What is your highest level of education in:

   a. nursing

   b. other (if applicable)

BACKGROUND INFORMATION
(Nurses)

1. What is your age?

2. What is your highest level of education in:
   a. nursing

   b. other (if applicable)

3. How many years of nursing experience have you had?

4. In what areas of nursing have you obtained most of your experience?

APPENDIX E
NUMERICAL ANALYSIS OF JONES DATA

1. LATENT PARTITION ANALYSIS

Latent partition analysis estimates the number of categories or partitions underlying the observed data. It first generates a matrix of estimated probabilities indicating the probability that each item belongs to each category. By examining the items with high probabilities in each category, the clusters can be identified in much the same way as factors are found in exploratory factor analysis. In this analysis, a five-cluster solution was the most interpretable, as shown in Table E1. In the table, the column headed 1-delta^2 represents the probability that the item would be sorted in the same observed category as other items found in the cluster. In effect, it represents how much (or how little) agreement there is that items should be sorted together. Higher values represent strong agreement; thus, a high value in this column suggests that the placing of the items in that category is quite unequivocal. The remaining columns of the table describe the probability of the items belonging to each latent cluster. They can be interpreted as being similar to factor loadings. In a strong solution there should be one high entry for each item, with the remaining entries near zero. For clarity, only probabilities that are higher than .30 are reported here. Note that entries greater than 1.0 are an

Table E.1 Latent Partition Analysis of Faculty Judgments of Quality of Responses to the Jones Scenario

Cluster	Item	$1-\Delta^2$	Cluster Loadings				
			1	2	3	4	5
I	4	66	93				
	30	75	99				
	35	71	107				
II	29	25		45	34		
	24	24		50		36	
	5	45	58	72			
	36	36		76			
	26	38	42	79	45		
	22	25		79			
	18	48		91	32	35	
	25	42		92			
	32	53		108			
III	21	38		43	59		
	3	46		44	60		
	9	31			61		
	34	62		72	78		
	33	56		59	78		
	13	61			89		

Table E.1 continued

Cluster	Item	1-	Cluster Loadings				
			1	2	3	4	5
III	10	48			93		
	2	48			103		
	7	49			106		
	17	57			111		
IV	6	18		31		50	
	16	39	40	31		52	
	20	58	48	-46	62	64	
	31	51	46	30	-35	69	
	11	19				72	
	8	26				75	
	23	29				81	
	19	39				100	
	37	58				123	
	27	50				132	
V	28	60		-72	61		75
	15	53					85
	12						100
	14						108
	1						114

indication of a poor fit of the model to the data. Clearly, some items could not be placed cleanly in any one category. This result suggests that there are about five "quality" categories underlying the responses, and that there was less agreement on some items than on others.

2. COLLAPSING OF QUALITY CATEGORIES -- JONES

Table E.2 shows the results of the process of collapsing quality categories into five. In the table, category 1 represents "best" responses, and category 5, "worst" responses. Numbers appearing in each cell indicate which written responses (numbered 1 to 37) were selected by each faculty member for each quality category. The categories that were collapsed together are shown in parentheses at the bottom of each cell. Note that for all but one faculty member, categories one and two were left unchanged, as the respondents had indicated that the "best items stood out".

Results of the collapsing process are shown in a somewhat different way in Table E.3. In this table, the number of faculty placing a response in a particular category is shown. For example, item #1 was placed in category 1 by one faculty member, in each of categories 2 and 3 by one faculty member, in category 4 by five raters, and in category 5 by four

Table E.2 Placement of Responses Into Categories of Quality (Collapsed) by Faculty -- Jones Scenario

Faculty Member	Quality Category 1	2	3	4	5
1	11,19	2,3,8,16 18,22,27 37	1,7,9,21 23,24,31 32,34,36	10,13,15 17,20,28 29,30,35	4,5,6,12 14,25,26 33
2	16,18,26 30,31,37	4,5,35	2,3,9,13 17,21,22 24,25,29 32,33,34 36 (3,4)	1,6,7,10 11,12,14 15,20,23 27,28 (5,6)	8,19 (7)
3	8,11,16 22,24	2,27,29	3,4,5,13 18,19,20 23,26,30 32,35,36 37 (3,4)	6,7,9,10 17,21,25 31,33,34 (5,6)	1,12,14 15,28 (7)
4	11,19,23 27,37	2,3,7,9 10,13,15 17,18,20 21,22,24 25,29,32 33,34,36	4,5,8,16 26,30,31 35	1,12,14 28	
5	11	22	18,19,23 27,31,37	2,3,4,5 7,8,9,10 12,13,16 17,20,21 24,28,30 32,33,34 35	1,6,14 15,25 26,29 37 (5,6,7
6	12,16,19 21,28,30 31	1,4,6 14,18,24 25,26,32 36	2,7,13 23,33,34	8,10,11 17,20,22 27,37 (5,6,7,8)	3,5,9 15,29 35 (9,10 11)

Table E.2 continued

Faculty Member	Quality Category 1	2	3	4	5
7	8,11,19 20,26,30 31	3,4,5, 18,35	13,16,21 22,24,29 32,34,36	1,12,14 15,25	2,6,7 9,10,17 23,27,28 33
			(3,4)	(5)	(6,7,8)
8	4,6,8 16,19,20 24,27,31 37	3,5,10 13,18,21 22,23,25 26,29,30 32,33,34 36	2,9,11 17	1,7,12 14,15,28 35	
9	1,14,22 32	8,12,19 21,24,28	2,7,33 34	3,4,5,10 11,13,16 17,18,20 25,29,30 31,35,36 37	6,9,15 23,26 27
10	4,5,8 9,16,18 22,26,30 31,35,37	11,19,20 27,29,36	2,3,7 13,17 23,24	6,10,21 24,25,32 33	1,12,14 15,28
	(1,2)	(3)	(4)	(5,6)	(7)
11	11,18,22 26,30,31 35,37	5,6,8,16 23,27,34 36,37	4,7,10 13,14,17 19,20,21 26,30,35	1,2,3,9 12,15,25 28,29,33	
12	11,37	2,3,22 23	8,10,13 16,18,19 21,24,31	4,5,9,17 20,25,26 27,29,30 33,34,35 36	1,6,7 12,14 15,28 32
	(1)	(2)	(3,4)	(5,6,7)	(8)

Table E.3 Frequency of Placement by Faculty (n=12) of Items Into (Collapsed) Categories -- Jones Data

	Category				
Response	1	2	3	4	5
1	1	1	1	5	4
2	0	4	5	2	1
3	0	5	3	3	1
4	2	3	3	3	1
5	1	4	2	3	2
6	1	2	0	3	6
7	0	1	5	4	2
8	4	3	2	2	1
9	1	1	3	4	3
10	0	2	2	7	1
11	7	1	1	3	0
12	1	1	0	6	4
13	0	2	7	3	0
14	1	1	1	4	5
15	0	1	0	5	6
16	5	2	3	2	0
17	0	1	4	6	1
18	3	5	3	1	0
19	5	2	4	0	1
20	2	2	2	6	0
21	1	3	5	3	0
22	4	5	2	1	0
23	1	3	5	1	2
24	3	3	4	2	0
25	0	3	1	6	2
26	3	2	3	1	3
27	2	4	1	3	2
28	1	1	0	6	4
29	0	4	2	4	2
30	4	1	3	4	0
31	6	0	4	2	0
32	2	3	4	2	1
33	0	2	3	5	2
34	0	3	6	3	0
35	1	2	3	5	1
36	0	5	4	2	1
37	6	2	2	2	0

raters. Responses 11, 31 and 37 were classified as "best" by at least half the respondents, while items 6 and 15 were considered worst by 6 or more respondents.

APPENDIX F
NUMERICAL ANALYSIS OF SMITH DATA

1. LATENT PARTITION ANALYSIS

Results of the LPA conducted on Smith data are shown in Table F.1 Although a five cluster solution was retained, 1-delta^2 was low for all items, and many of the items loaded on a number of different categories, which suggests that there was little agreement about how the items should be sorted. Associated with a five-cluster LPA output is a 5x5 matrix called the confusion matrix, which reflects the estimated probability that items placed together on this analysis would be placed together on independent repetition. Values in the confusion matrix suggested that the solution was very unstable, that is, items could be expected to "move around" from cluster to cluster.

Table F.1 Latent Partition Analysis of Faculty Judgments of Quality of Responses to the Smith Scenario

Cluster	Item	1-	Cluster Loadings				
			1	2	3	4	5
I	24	25	53	31			
	13	46	75	-75	58	48	
	9	27	82				
	3	46	87			64	-35
	18	43	97				
	7	45	103				
	20	53	108				
	22	70	113	52			
	37	52	122				
II	23	33		38	32		37
	21	27		47	36		
	2	36		56	38		
	11	34		70			
	15	48		72	-43	39	33
	8	34	36	76			
	14	54		79		51	
	19	44		92			
	16	53		105	30		
	28	51	-30	117			

Table F.1 continued

Cluster	Item	$1-\Delta^2$	Cluster Loadings				
			1	2	3	4	5
III	35	35			51		47
	10	32			73		
	4	34			80		
	32	51	-30		109		
IV	1	40				53	
	17	41	-30			76	
	27	30			42	79	-31
	36	38		47		80	
	33	47	-40		-44	92	
	6	37			30	103	
	5	47				109	
	31	48				115	
V	12	45					60
	30	47	33				68
	26	54		44			69
	25	74					104
	29	88					116

2. COLLAPSING OF QUALITY CATEGORIES -- SMITH

Table F.2 shows the results of the process of collapsing quality categories with Smith data into five. Again, category 1 represents "best" responses, and category 5, "worst" responses. Numbers appearing in each cell indicate which written responses (numbered 1 to 37) were selected by each faculty member for each quality category. The categories that were collapsed together are shown in parentheses at the bottom of each cell.

In Table F.3 the results of the collapsing process are shown in a different way. This table indicates the frequency with which faculty placed the responses into the five categories. Fifteen of the 37 responses were placed in the full range of categories, that is, were rated from one to five; ten items were rated from two to five; and nine were classified from one to four. Two items were rated in categories one to three, and one in categories three to five.

Table F.2 Placement of Responses Into Categories of Quality (Collapsed) by Faculty -- Smith Scenario

Faculty Member	Quality Category 1	2	3	4	5
1	8,9	3,7,18 20,22,34 37	4,10,11 15,19,28 35	2,16,21 23,24,26 27,31,32	1,5,6,12 13,14,17 25,29,30 33,36
2	15,18, 20,22 26,29 30,35 37	3,11,36	1,2,7,8 10,12,13 14,16,17 19,21,23 27,28,31 33,34	6,25	4,5,9 24,32
	(1)	(2)	(3,4)	(5)	(6)
3	9,11,18	4,12,20 23,26	1,3,6,13 24	2,7,8,10 14,15,16 19,21,22 25,28,29 30,32,34 35,37	5,17,27 31,33,36
	(1)	(2)	(3)	(4,5)	(6)
4	4,7,8 10,18 24	11,16,20 22,23,37	2,3,9,13 19,21,32 34,35,36	1,5,12 17,25,26 28,29	6,14,15 27,30,31 33
	(1)	(2)	(3,4)	(5)	(6)
5	8	3,9,13 20,22,27 37	4,10,11 16,17,18 19,21,28 32,34,35	7,23,24 30	1,2,5,6 12,14,15 25,26,29 31,33,36
	(1)	(2)	(3,4)	(5)	(6,7)
6	9,27,37	1,2,7,8 11,12,14 15,16,18 19,20,21 22,23,24 25,26,28 29,30,34 36	6	3,4,5 10,13,17 31,32,33 35	

Table F.2 continued

Faculty Member	Quality Category 1	2	3	4	5
7	3,9	1,7,18 20,22,23 34,37	10,21,24 26,28,36	2,4,8 11,13,14 16,17,19 27,30,31 32	5,6,12 15,25,29 33,35
	(1)	(2,3)	(4,5,6,7)	(8,9,10,11)	(12)
8	7,8,9 16,18,22 24,34,37	1,3,4,5 6,19,21 31	2,10,11 12,13,14 20,23,25 26,29,30 32,35	15,17,27 28,33,36	
9	1,3,4,8 9,10,11 16,18,19 22,27,37	13,17,23 24,32,34 35	5,6,7,14 15,20,21 26,28,30 31,36	2,12,25 29,33	
10	3,7,9 13,19,20 22,24,36 37	10,11,12 18	1,15,23 25,26,29 30,35	8,21,27 28,31,32	2,4,6 14,16,17 33,34
11	9,10,23	2,4,5,7 13,18,20 21,30,37	1,3,6,8 11,12,14 15,16,17 19,22,24 26,27,28 31,34,35 36	25,29,32 33	
12	8,9,24 27,28, 36,37	3,7,10 12,13,18 20,22,23 34	1,4,11,16 19,25,26 29,30,35	4,6,14 15	2,17,21 31,32,33
	(1,2)	(3)	(4,5)	(6,7)	(8)

Table F.3 Frequency of Placement by Faculty (n=12) of Items Into (Collapsed) Categories -- Smith Data

	Category				
Response	1	2	3	4	5
1	1	3	5	1	2
2	0	2	4	3	3
3	3	4	3	2	0
4	2	3	3	2	2
5	0	2	1	3	5
6	0	1	4	2	5
7	3	5	2	2	0
8	6	1	2	3	0
9	9	1	1	0	1
10	3	1	5	2	1
11	2	4	5	1	0
12	0	4	3	2	3
13	1	4	4	2	1
14	0	1	3	4	4
15	1	1	3	4	3
16	2	2	4	3	1
17	0	1	3	4	4
18	5	6	1	0	0
19	2	2	6	0	0
20	2	8	2	0	0
21	0	3	5	3	1
22	4	6	1	1	0
231	1	6	3	2	0
24	4	2	3	2	1
25	0	1	3	5	3
26	1	2	6	2	1
27	3	1	2	4	2
28	1	1	6	4	0
29	1	1	3	5	2
30	1	1	4	3	3
31	0	1	3	4	4
32	0	1	3	6	2
33	0	0	1	4	7
34	1	5	4	1	1
35	1	1	7	2	1
36	2	2	4	1	3
37	6	5	0	1	0